Resident Physician

Journal for the Hospital Staff Officer

when he smokes too much . . .

Whenever indigestion results from habitual overdoing in any form (excess of cigarettes or alcohol, dietary indiscretion, nervous tension), symptoms can be quickly alleviated night and day with Gelusil and the new formulation Gelusil-Lac.

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WARNER-CHILCOTT

100 YEARS OF SERVICE TO THE MEDICAL PROFESSION

May 1957, Vol. 3, No. 5

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Resident Physician

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Articles

The Resident Physician is published monthly on the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Boulevard, Manhasset, New York. Accepted as controlled circulation publication at East Stroudsburg, Pennsylvania. Postmaster: If undelivered, please send form 3579 to Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

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Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians. When possible, two copies of the manuscript should be submitted. Articles with photographs, illustration or drawings are especially desired.

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An evaporated milk formula costs half as much as a proprietary formula and it supplies additional benefits. The considerable savings, over the formula period, can be important to many young parents.

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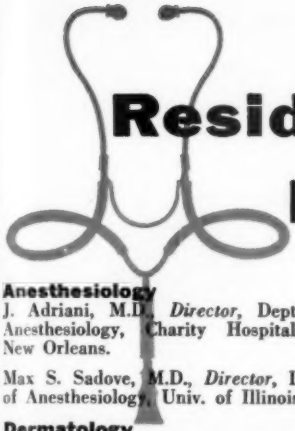
Carnation

"FROM CONTENTED COWS"

Optimum prescription-quality in today's trend to the individualized formula.



Resident Physician

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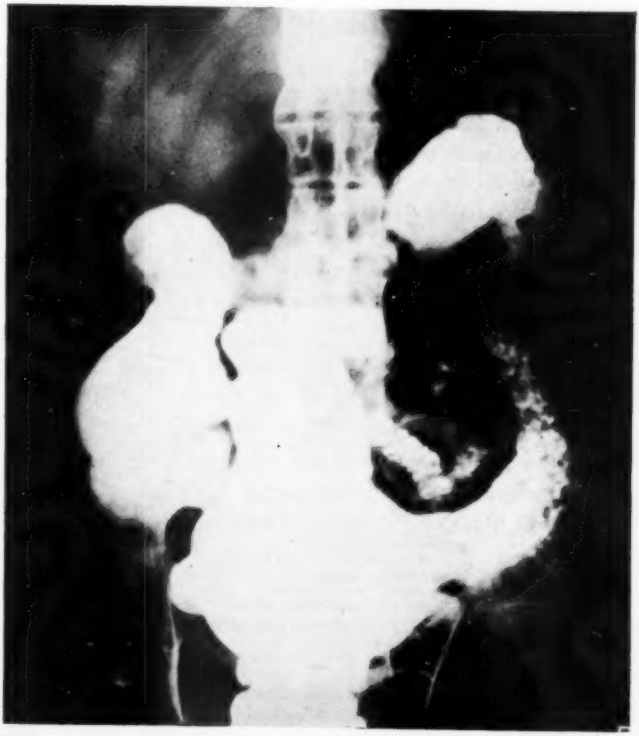
Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

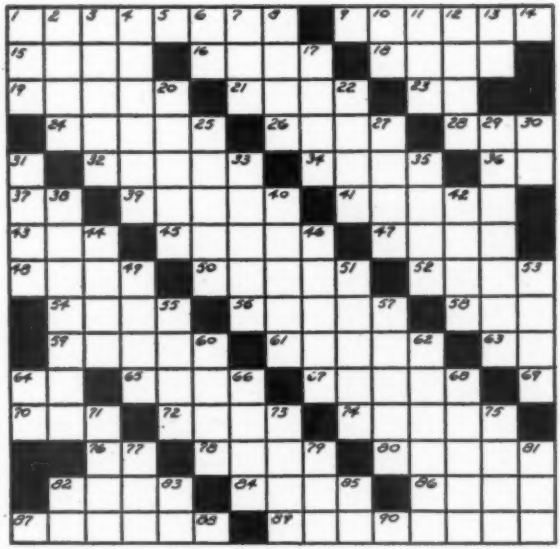
Which is Your Diagnosis?

1. Congenital polyposis
2. Normal
3. Pseudopolyposis (repair stage of ulcerative colitis)
4. Carcinoma

(Answer on page 178)



Resident Relaxer



ACROSS

1. An incision into the iris
5. To correct, as a dislocation
10. Poisonous Javanese tree
11. Antiaris Toxicaria
12. To keep in health
13. Deprived of sensation
14. By mouth (2 wds.)
15. The intravital stain formed by oxidation of dioxyphenylalanine
16. Erbium (symb.)
17. Point of greatest depression
18. Lymph "gland"
19. Like, or way (Suffix)
21. Gram
22. Compound of albumin and iodine
23. Blood constituent (Pl.)
24. Spanish article
25. Aluminum (Symb.)
26. Green (Comb. form)
27. A focus of infection
28. Equal
29. A thread passed through the skin to make a fistula
30. Peaceful
32. Cicatrix
34. Wise men
35. Dope (Slang)
36. —— Tieute, Javanese poison
37. ——or Palpebrae
38. An important association
39. Mole
40. Crystalline alcohol from rue, etc.
41. Argon (Symb.)
42. Without date (Abbr.)
43. Goddess of discord
44. Pertaining to the calf
46. Teaspoon
47. Three (Prefix)
48. Any space within boundaries
49. Pertaining to the kidney
50. cc.
51. To be (Fr.)
53. ——ant, hissing
55. "Let there be made," (Lat.)
57. ——megaly, Marie's Disease
60. Without (Lat.)
62. Dwarfishness
64. Let it stand (Abbr.)
66. Bristle
68. Lip (comb. form)
71. Secondary amine
73. Parts of a circle
75. ——ment, Rus this in
77. Experimenter's locus operandi
79. Before
81. Guided
82. Iron (Symb.)
83. Thulium (Symb.)
85. Bone
87. Boron
88. Gram
90. Alpha

87. Simex lectularius
89. —— bone, the patella is one

DOWN

1. The eye starts as one (Embryol.)
2. Not healed
3. Strange (Lat. Pl.)
4. Afferent
5. Temperature (Abbr.)
6. Mouth
7. Rabid
8. French physician (1848-1913)
9. Roentgen
10. In (Prefix)
11. Owing
12. Prominence on the tympanum
13. Columbium (Symb.)
14. Out (Prefix)
17. Tale (Gk.)
20. Prolonged deep inspirations
22. —— Fever, Dengue
25. Actors' parts
27. Man's name
29. Fibroma
30. Extension on a building
31. Auscultatory ——, trou auscultatoire
33. Dorsal
35. Belonging to national dental society
38. Pertaining to a small cavity
40. Eponym of interventricular septal defect
42. Bone of the forearm
44. Coitus without consent of the woman
46. Birth mark
49. Talk deliriously
51. Full (Lat.)
53. Verruca
55. Calf of the leg
57. Wearies
60. Father
62. Dwarfishness
64. Let it stand (Abbr.)
66. Bristle
68. Lip (comb. form)
71. Secondary amine
73. Parts of a circle
75. ——ment, Rus this in
77. Experimenter's locus operandi
79. Before
81. Guided
82. Iron (Symb.)
83. Thulium (Symb.)
85. Bone
87. Boron
88. Gram
90. Alpha

Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request your name will be withheld.

Basic Science

The article "A Residency Year in Basic Science," by Dr. Frank A. Howard, interested me very much. As a graduate of the Philippines, I also feel the need for such a review. However, he does not point out which of these schools have approved courses. I will therefore appreciate it if you will furnish me with a list of approved courses in the basic sciences. I am a resident in general surgery.

Constancio C. Tan, M.D.
St. Vincent Charity Hospital
Cleveland, Ohio

• *A list was published in the Journal of the American Medical Association, Volume 161, Number 17, August 25, 1956, Page 1649.*

First Weeks

Request permission be granted the Army Medical Service School to reproduce the article, "Your First Weeks in Army Basic Training," from RESIDENT PHYSICIAN, February 1957, Volume 3, No. 2, pages 43-50. It will be appreciated if you will indicate if the above material may be reproduced and used for resident and nonresident instruction.

Lester H. Dacus
2nd Lt. MSC
Assistant Adjutant
Army Air Force
Medical Service School

• *Permission granted, of course.*

Chicago Surgeons

I note that on page 126 ("Resident Roundtable," RP, MARCH 1957) Dr. Eller states that at The University of Chicago Clinics—"Every case is a service case in that the patients, even though they pay a full private rate, are told that they will be operated on and treated by the house staff under the supervision of the full-time men."

This is not correct. The over-

—Continued on page 30

—Continued from page 22

whelming majority of our patients are operated upon by the Senior men on the surgical staff. When any patient expresses a desire to have an individual surgeon perform his operation, that surgeon does the surgery. Competent residents operate upon patients who do not express a desire that their surgery be done by one of the Senior men. In these instances, Dr. Eller is quite right in stating that the operation is done under the supervision and usually with the assistance of one of the full-time men.

Lester R. Dragstedt, M.D.
Chief of Service, Surgery
University of Chicago Clinics
Chicago, Illinois

• *Dr. Eller was contacted regarding his statement. His reply, in part, follows:*

"I stand corrected and regret the erroneous impression I created concerning the clinics at the University of Chicago. . . . "

Thank you for taking the trouble to point out the error in our Resident Roundtable.

VA Research

We greatly appreciated receiving the Veterans Administration Residency Training and Hospitals issue of RESIDENT PHYSICIAN. In reviewing that portion referring to this hospital it was found that all residencies were not listed properly, or not shown at all. The following is a list of programs and program lengths at VA Research Hospital, Chicago, Ill.: Allergy (1), Anesthesiology (6 Mos.), Dermatology (3), Gastroenterology (2), Internal Medicine (3), Neurosurgery (4), Ophthalmology (1), Orthopedic Surgery (4), Otolaryngology (1), Pathology (4), Physical Medicine (3), Radiology (3), General Surgery (4), Urology (3), and Thoracic (2). All of these programs have been approved by the American Medical Association. We also have a rotation program with the VAH, Downey, whereby residents in psychiatry and neurology rotate to this hospital for training. All of the above are also affiliated with the Northwestern University Medical School Center.

R. A. Allen, M.D.
Director, Professional Services
Veterans Administration
Research Hospital
Chicago 11, Illinois

Licensure

. . . your article on licensure for foreign physicians in New York State just came in time. We *had* secured a job there [New York]—nobody mentioned any Licensing Laws! Only for you we might have been jobless in July if we were to wait until then to discover the real situation. . . .

Name withheld
Nashville, Tennessee.

I have received the February and

—Concluded on page 36

—Concluded from page 30

March edition of your journal and I have enjoyed it enormously. I would like to thank you very much.

On page 45 in the March edition you deal with the problems a foreign trained physician has, once he comes here as an Exchange Visitor or as an immigrant. I would be glad to give you some of my thoughts in this respect if you wish so. Last month you began a series on "Licensure for Foreign Graduates." I found it very hard to find sufficient information about this and I am glad you started this series. However, it will take a long time until you get through all 48 states. I am slightly under pressure in this respect and would like to find out the possibility of taking the examination in one of the states. However, I am a Visitor in the states and wonder whether any one of the states permits an Exchange-Visitor to take the medical examination to obtain a license to practice medicine.

Walter Peters, M.D.
The Buffalo General Hospital
Buffalo 3, New York

• *California, District of Columbia, Indiana, Oklahoma, Washington State, Guam and the Virgin Islands. Certain other states offer temporary licenses to non-citizen physicians-in-training.*

Missing Issues

The last issue I received of your stimulating journal was that of July 1956, when I was a resident in Colorado Springs. Despite sending in a change of address, I have not received a single copy since, though did manage to scrounge up a January 1957 issue from a friend. Would it be possible for you to send me the missing issues? I might add that I am now a resident in radiology at Walter Reed Army Hospital, and was initially impelled to inquire into and accept the program here on the basis of an excellent article appearing in an early 1956 copy of RESIDENT PHYSICIAN.

Walter G. Gunn, Capt. M.C.
Walter Reed Army Hospital
Washington, D. C.

• *Back copies are on the way. Your name is back in our mailing file. We hope you will continue to find forthcoming issues of interest and value.*

Perrin H. Long, M.D.

Editor's Page

The Resident and His Interns

In the eyes of the intern, a resident can be either deity or devil. Understandably, the intern's view is determined primarily by the comportment of the resident with his junior staff.

Although winning an intern popularity contest is not the proper objective of the resident, his instruction, encouragement and understanding of the interns on his service is one of his major responsibilities.

In order to live up to this important purpose, the resident should not forget that interns, like patients, are human beings, deserving of respect and responding favorably to kindly and thoughtful treatment. The first rule in the Resident's Book of Conduct should be: *Be considerate of and polite to interns.*

This attitude on the part of the resident inevitably instills confidence in the intern. Additionally, it engenders an atmosphere of confidence and respect for the entire house staff on the part of patients and ward personnel.

A second axiom in the resident's book should read: *Be at all times a mentor and a tutor to your interns.* As the resident can readily recall from his own recent experience, interns usually have a few problems of a professional, economic, emotional or social nature. The resident, having been through the intern mill, is in the perfect position to advise and assist

the intern, particularly in those matters which concern professional and emotional difficulties. The resident must be an honest and faithful counselor to his interns.

A good resident protects his interns, stands up for them before the hospital's administrators. He doesn't make excuses for their faults, but he works hard to help the intern overcome them. He must see and nurture the promise which is present in each member of his junior staff. The resident, ever aware of his fallibility, discusses the management of patients with his interns; he does this quietly in the ward office. Never does he raise his voice in criticism of patient care when in the presence of the patient or ward personnel. He is scrupulously careful never to blame the intern for his own shortcomings.

The resident is the most important individual in the intern's graduate educational program. He should constantly think of himself as a tutor. As such, he must devote much of his time to the study of his patients and to reading so that he is prepared for his daily role as teacher of his intern staff; too much emphasis cannot be given this point. The intern learns primarily from his resident.

The third and last verse in the resident's book reads: *The resident must gain maturity of spirit and confidence in his own judgment if he is to command the respect of his interns.* In your Editor's own experience, there is nothing more devastating to patient care, ward management and intern teaching than to have, in charge of a ward, a resident who is immature, nervous and lacking in self-confidence. Under these conditions everything goes to pot. The patients promptly sense the difficulties and lose confidence in the judgment of the resident. Nurses and attendants become jittery and unsure. Interns vegetate in states of bewilderment, annoyance and at times, actual fear. To recoup from such a situation is practically impossible. And whether deity or devil, preventing this situation from occurring in the first place is almost entirely in the hands of the resident.

Perrin H. Long.

Choosing Your Office Assistant

A capable office assistant is a vital ingredient of success in private practice. Here are some tips on how to find that perfect Gal Friday.

EVERY physician can use an office assistant. Many, if only because of the size of their practices, coupled with a lack of talent in office management, just couldn't get along without one.

But how about the new physician just opening up in solo practice? Does he really need a Gal Friday—and if so, how does he go about picking a good one?

The *need* of an assistant is relative. Take the resident just launched in his specialty who spends the first three months in his new office reading journals, talking to detail men, and just generally going through that agonizing period of waiting by his newly-installed, never-ringing telephone. Obviously, this poor soul doesn't really *need* an assistant.

But, how long can a condition of no patients exist? Resources — yours or anyone else's — are limited. Besides, though the new OB man may go a couple of weeks in some areas without a single patient, the internist, pediatrician, general practitioner, radiologist and so forth cannot and should not expect to endure a long siege of nothingness.

The telephone *will* ring, patients *will* shuffle into your waiting room. Your appointment book *will* begin to take on a pleasant clutter of names which increase in number from week to week.

Confusion

Now comes the question: Who will handle your bookkeeping, billing, patient history cards, treatment records, bank deposits (a pleasant thought), withdrawals (a necessary thought), and arrange for appointments? Who will take your telephone calls when you're in the middle of an examination or procedure? Who will help you in your lab work, remind you of your inventory of various supplies, fill out the multitude of insurance forms required of the modern day physician?

Your wife? Temporarily, maybe. But not forever.

Oh, sure, you can try it yourself. But if you do, your office will take on the quaint confusion of a country grocery store and you'll stumble around with the harassed appearance of a short order cook in a highway diner during the noon rush.

Also, you'll mess it up. Meticulous at first, you'll begin abbreviating as your practice grows. Your short cuts in paper work will lead to procrastination and finally, to utter confusion. First your financial records will get into a mess, and then your patient records will become incomplete, unintelligible and valueless. And then, the ever alert, doctor-conscious T-men may step in to review your income tax situation.

An awful prospect? Of course it is. And unfortunately it happens too often to be anything but dismally unfunny and decidedly dangerous to you, your patients and your professional pride (not to mention your income).

From the first

Does this mean you must have an assistant to do your office work right from the first day?

Not necessarily. According to one physician who has just completed his second year in internal medicine practice: "No one in his right mind would advise a pelvic being performed without the immediate presence of another woman. Obviously then, the OB, internist and GP must

have a woman assistant from the very first day in private practice. Other specialists, likewise. Not so the pediatrician, ophthalmologist, psychiatrist, ENT man. These specialists often go it alone for a period of time . . . not too long, but long enough for the practice volume to justify the extra overhead for help."

But eventually, almost every physician and surgeon should have an assistant.

She should be able to type, keep records, and answer the telephone at the very least.

At best, she should take over as your office manager, be trained in laboratory procedures and be able to handle stenography.

Of course, in some surgical specialties, you could use a registered nurse in your office from the outset. In other specialty practices an RN may well prove to be worth her weight in gold, but only after the gold becomes available.

Able to give specific treatments under your supervision and skilled in the many techniques involved in histories and examination, the RN can take much of the burden of the routine of a busy practice from the doctor's shoulder. But, generally speaking, you can get by without one for a while.

Assuming you will be hiring some sort of office help within a few weeks of your private practice inaugural, what skills should you require of an assistant? What will you have to pay for her services and where can you locate her?

Appearance

First, a good appearance should be high on your list of requirements. By this we don't mean beauty.

Posture, cleanliness, attitude, the ability to walk from one place to another without causing commotion or emotion, all these can be considered part of appearance. If a gal has a good appearance, you can count on one thing for sure: she works at it.

Not beauty

Despite the obvious argument certain to align itself against the fact, Marilyn Monroe would not make a good receptionist for your office. Her appearance is against her.

Remember, we are not discussing *your* pleasure at her general atmosphere of sultry beauty. We can assume that without question.

But as a mere physician, you are certain to take second billing to

MM in any situation—and it would be distinctly detrimental to your new practice (after the first mad stampede of patients) if you presented an attraction such as this as your receptionist.

(Not that you'll be able to get Marilyn to accept the position at $60 a week anyway, but the point of *too much beauty* is important.)

Just as you wouldn't want an outstanding beauty (such as Madison Avenue might fight to employ), neither would you want a young lady whose physical unattractiveness would be a disturbing factor in the decor and atmosphere of your practice.

Therefore, the best rule might be —a gal who is nice looking, neat, absolutely clean, suitably-dressed (a matter of taste, not expense), of pleasant disposition and impeccable manners.

Do such gals exist? Absolutely. And by the thousands. But, there is more required of a good office assistant which cuts the supply down to size.

Telephone manners

In addition to the qualities mentioned previously, your helper will need certain acquired skills.

The first of these might be termed a *telephone personality*. This may be a combination of many things including a pleasing voice; sympathetic, warm courteous and without too much emotion. Avoid the tense, terse, grating, or gossipy telephone terror. She can turn a good practice into a nightmare in less than a week—and kill it completely in less than a month.

How about diction? Again, like beauty, it must be adequate—but a little goes a long way. You don't want an Oxford accent, nor will you be happy with the vernacular of the waterfront. There is an acceptable middle ground.

Also, your gal must be able to answer simple questions quickly and be able to sidetrack more technical questions in an adroit and courteous fashion. It's perfectly obvious that the giddy gal who hems and haws over a question such as: "What time is it?" is not a person to be counted on to handle the volume of phone calls you hope to have in your practice.

But how can you find out whether or not a would-be office helper has a good telephone personality?

Nothing could be simpler. As a part of your original screening operation make it understood by any agency or in any advertisement you place in a "help wanted" section of your newspaper that you wish all applicants to contact you by telephone, first.

In this way you'll be able to eliminate from consideration those who obviously won't qualify as far as their telephone manner is concerned. Keep in mind, however, that you are seeking a pleasant, clear voice—some timidity or nervousness is to be expected at first from younger applicants, of course. If you are undecided, ask applicants a few questions for which they should have ready answers, i.e., the extent and nature of their schooling, how far they must travel to reach your office, past work experience and so forth.

Keep in mind that Miss Telephone is extremely important. What she says as your assistant has a tremendous influence on your practice. Here is your main point of public contact. In her rests, to a large extent, your public relations.

The telephone interview may be brief, but it is always revealing. Listen for the girl who volunteers a long involved opinion on a trivial matter. Avoid her like poison. As a philosopher she'll volunteer long explanations on the nature, cause and cure of your patients. This would be endurable—except for the fact that she inflicts these lectures not upon you but on your patients.

Happy medium

You don't want the town gossip on your office telephone. Neither do you want a frustrated pseudo medic who reads all the magazine articles on physical and emotional disorders and thereby becomes a diagnostician without diploma.

One such office secretary reportedly kicked off a remarkable series of events. A patient, asked by the secretary the purpose of her visit to the doctor's office, answered: "He's treating me for simple anemia." Whereupon the sensitive and "well-read" secretary, reversed in her understanding of leukemia and anemia, threw up her hands and began to sob.

The patient, jarred by this display

of emotion, immediately concluded that the doctor had been hiding the horrible facts of her illness, shielding her from the awful truth. She fainted on the spot.

It was almost an hour before the doctor, after calming down the secretary (who thought the patient had dropped dead) was finally able to convince the patient that she was not doomed.

He fired the secretary, of course. But he had three different girls in the subsequent two months. Seems he was somewhat poisoned by the experience and has never really trusted a secretary since.

Steer clear of the girl who is too gabby, too bright, too gay, too flippant on the telephone. She'll not only drive you nuts but all your patients, too.

Typing

How about typing? Although a doctor isn't a lawyer and doesn't require thousands of documents expertly typed, the average physician requires the typing of patients' bills each month, case records, some correspondence and certain reports such as consultations, referral requests, and progress notes.

However, a girl with some basic knowledge of typing is adequate for this purpose. A high school typing course or a short secretarial school course is all the training necessary in most instances.

Shorthand

Shorthand is an asset, of course. It's not absolutely necessary, though. Also you'll pay for shorthand ability. Girls who have this skill come at a higher salary than girls with a basic knowledge of typing only. And finally, shorthand is being replaced by physicians who are becoming conditioned to use the various dictating devices.

Central dictation is becoming common in hospitals and residents are familiar with the operation of transcribing devices. You won't need a shorthand expert to transcribe your notes from a dictating machine. Just a typist.

Age

The age of the girl you employ is not a critical factor. But there are definite advantages and disadvantages common to the different age groups.

Generally speaking, girls of high school age are indifferent and ineffective, not solely because of their own attitude or ability, but because of the attitude of your patients when they are confronted (or affronted) by a "young snip of a thing." Many will not appreciate being required to deal with a teen-ager. Also, you will have an added responsibility in employing a minor—especially of the female sex. And as for her being present during physical examinations of female patients, it doesn't work out in most cases.

Maturity

Also a certain emotional maturity is required of your secretary. This is rather rare in the recently graduated high-schooler. At this age, a few years make quite a difference in poise, efficiency and stability. Finally, patients may wonder at the safety of a confidential patient-doctor relationship when a youngster has access to records. Of course, the individual merit of the girl in question will offset many of these objections and should be considered.

On the plus side: You will run your office as no other doctor before or after you will run his. You are an individual and will require that certain things be done *your* way.

So keep in mind that any girl will take a certain amount of time before she becomes accustomed to your way of thinking and your way of running a practice. Most younger people are malleable and can learn with amazing rapidity. Also, they are inclined, when conscientious, to come to you for every little thing when a decision is involved. This can be a good thing and keeps you in full control. But later on, you will expect her to begin to accept responsibility. Some can. Most cannot.

College age

What of the girl of college age, from 18 to 22? Many physicians say they are the best workers and are sympathetic, industrious and mature enough to accept some responsibility also, intelligent enough to

make minor decisions. But there's one rub. They are eligible and interested in marriage. This natural state of association between the sexes finds the majority of takers among this age group. The turnover in your secretaries will probably be rapid. Since, regardless of former training, it takes time to fit a girl into your own routine of office management, you'll find a quick turnover of secretaries confusing and troublesome.

Yet, the college graduate may be your best bet. But be careful in your choice.

Despite the male's traditional resentment of the unmarried career gal (unnatural, cold, officious, lacking in that indefinable "soft and sympathetic" quality which to many men characterizes femininity) ages 33 to 40, it is in this group that you may find your most dedicated and valuable secretary. Interested in medicine with the idea of "helping other people with their problems," many women in this group will become absorbed in your office routine and patient problems.

Often this gal can be nicer to your patients than you can—simply because she may take the time and trouble to be extra patient and understanding.

Your assistant must be loyal to you, of course, and that quality too, may manifest itself among the group just mentioned to a greater degree than in any other age group.

The *right* gal from this group, in fact, will make the perfect secretary.

Diplomacy

How about the widowed woman or the married woman in her fifties who is working because her children are grown and are out in the world? Generally, she will make a fine office assistant. A good manager, experienced in social conventions, tact, diplomacy, mature and capable of making decisions.

Her only drawback: She may be inclined to do things her way rather than *your* way unless you are definite in spelling out to her exactly what you expect and demand of your secretary. Also, because of her age, she may be inclined to be somewhat officious when dealing with younger patients.

Yet, by and large you will find the majority of women in this age category will make conscientious and industrious secretarys. One other thing: If she doesn't seem to fill the bill after a trial period, you've got a job on your hands. That is, of course, unless you are experienced in firing mothers. It isn't easy to tell her she's through—yet to carry her along will definitely bring about more problems as time goes on.

Sources

Assuming you are ready to go hunting for a secretary, how much of a job is it? Actually, whether you go through an established medical agency—being sure to particu-

lize the skills you do *not* require as well as those you do want—or whether you decide to advertise locally, you'll not meet with much difficulty in getting applicants. The actual selection of THE girl is a bit more difficult but your own common sense will be your biggest asset in this. One other source for secretaries, and an excellent one, is the community liberal arts college. They will have a placement service and will be happy to handle your request. The type of girl referred to you from the college will be among the best.

Part time

A word about part time help. You can do it, of course—hire a girl on the basis of a few hours a week. But somehow, there is no continuity of relationship, you with the secretary or she with the office. This will not make for a satisfactory situation on a permanent basis.

Eventually you will need full time assistance—and to delay for a few weeks is not economy in the real sense; especially when you consider that the best time to train a girl in your routine is when you have time to explain, discuss and answer all questions fully.

Given those early slack weeks of practice, you can do a thorough job of indoctrinating your secretary into bookkeeping, billing, telephone answering, patient records, journal indexing, filing, and all manner of things connected with your office. Also, if you are getting a secretary

trained in lab techniques, here is a chance to show her what is required without being interrupted or rushed in your explanation and demonstration.

Pay

The cost of full time secretarial help will vary according to the section of the country—but generally speaking you'll have to pay a good salary in metropolitan areas, less in rural sections. Competition for girls is increasing as industry expands; wages are soaring. You may expect to pay the following for an office assistant on a five day week with two weeks paid vacation, 6-10 holidays and sick leave:

TRAINING REQUIRED	BEGINNING* SALARY
High School	
Typing, filing, telephone	$50—$55
Plus stenographic	60— 65

College Graduate:		Registered Nurse	
Typing, telephone, filing	65— 75	(no steno)	75— 85
Plus stenographic	75— 85	Lab Technician (college trained—no steno)	75— 85

(*In metropolitan areas add 10%–15% to all figures.)

"Jack darling, call surgery."

Peter A. Volpe, M.D.

Guest Editorial

The Importance of Patient Care, Teaching and Research in the Training of Resident Physicians

Recently a student of cost accounting asked us; "You do three things here—you take care of patients, you teach students and you perform research. Which is your primary product, and which are the by-products?" We could only answer that we had three primary products, no one of which could be considered secondary. As to the by-products; each activity is in many senses a by-product of each of the others. As this student proceeded in his attempts to isolate the costs for patient care, for teaching and for research, he was frustrated by the inadequacy of any of his techniques to make separate accounting sense of the three interrelated activities.

Although we have posed a formidable problem for the cost accountant, we feel that there is a lot of good sense in the triad in which patient care, teaching, and research are closely integrated, sometimes to the point of becoming indistinguishable.

Much has been written and said about the mutual advantages inherent in a program which combines the three activities into an integrated whole. Medical Education's need for adequate clinical facilities was clearly pointed out in the 1910 "Flexner Report," and was the basis for much of the revolution which took place in Medical Education during the early part of this century. There is little doubt that a well rounded

PETER A. VOLPE, M.D.

Administrator
Ohio State University
Health Center

teaching program acts as a stimulus to the thoroughness and quality of patient care. Research, aside from its inherent teaching value, lends, by its presence, a critical and investigative atmosphere, one which is attuned to the newest and best methods of patient care and teaching. We will not belabor the point. Patient care, teaching and research fit logically together to form a mutually beneficial triad.

We may then ask; what are the ingredients of a program which will insure the proper balance in the three activities? Our cost accountant friend soon discovered the extent of the interrelatedness and indeed the interdependence of the three activities and objectives. Where three activities are so completely integrated, we have the urgent need for principles and mechanisms which will insure the existence of a setting in which the individual and combined objectives of patient care, teaching, and research can best be achieved. What then are some of the general principles which must be considered in achieving the balance?

Central Coordination. The close association of the three activities involves a certain amount of "give and take." Where each activity is left alone to struggle for its own objectives, an inevitable imbalance results. There is danger, also, that certain dichotomies will occur between various segments of the operation which will greatly reduce the potential and advantages of a combined approach. Clearly, policy decisions which affect more than one of these activities must be made by one well informed and sympathetic to the needs of all three activities.

The Team Approach. As previously pointed out, the three activities completely pervade and intermingle with the conventional lines of authority in the institution. It would be difficult to single out any segment of the operation or any job in the organization and say "that had nothing to do with teaching or research or patient care." It is important, therefore, that everything which is done in the institution be done with a genuine concern for the institution's three-fold purpose. From the top physician to the scrub woman it is imperative

that everyone realize his responsibility to the three objectives. There is a dignity to everyone's work in terms of the three-fold responsibilities.

Like any good teacher, the hospital must have wisdom. It must not become so concerned with the immediate and more tangible problems involved in the care of its patients that it fails to be sensitive to the needs of teaching and research. There are many things which a hospital must do, unrelated to economics, to fulfill its moral responsibility to its patients. When it shoulders additional responsibilities of teaching and research, economics is secondary to the hospital's satisfaction as measured in human values.

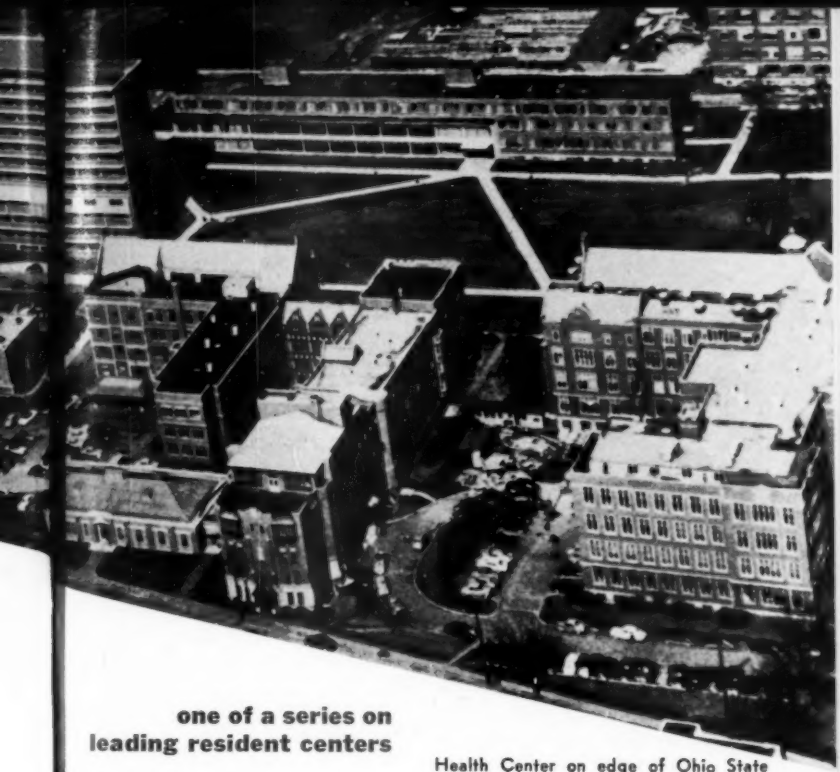
On the other hand, the Medical Staff and the House Staff in turn, must not neglect their obligations to the immediate problem of caring for the patients in the hospital. Obviously, there is little danger of this happening, but in the absence of certain safeguards, there is a possibility of tendencies in this direction. Where either attitudes or insufficient staffing result in less than the highest level of medical care, there cannot be the highest level of teaching.

These remarks raise relevant questions which the prospective resident may want to ask of the institutions which he is considering for a residency appointment.

It would seem appropriate for the resident to study the founding and current philosophies of the institutions in which he is interested as a key to the relative importance which they place on patient care, teaching and research. He will be most interested in the quality of teaching, but he must also consider the importance to him of the quality of patient care and research. He might also study the extent to which those in central control foster a policy which sets into motion a fully integrated program. In such a program, the three activities, having an ultimate and common objective, are welded into a mutually complementary triad which is translated into better health standards for all.

Ohio State University Health Center

An outstanding exponent of teaching and medical research, Ohio State's university-affiliated center offers residency appointments in 27 specialties. The center's 196 residents are faculty members of the College of Medicine, as are the 363 doctors on attending and courtesy staffs. Patients are about evenly divided between service and private.



one of a series on leading resident centers

Health Center on edge of Ohio State University Campus. Pictured are the College of Medicine, Dentistry, Starling-Loving Hospital which houses outpatient clinics, Institute of Pathology, and School of Nursing. At top is new University Hospital.

One of the newest and biggest. That phrase, though accurately applied to the vast, 128-acre, nine-building, Ohio State University Health Center, doesn't begin to touch upon the many qualities which have characterized the Ohio institution as a leader in American medicine.

Progress, however, is neither limited to nor accomplished by brick and mortar; long before the present modern facilities of the Ohio Health Center were even in the planning stage, men of vision and determination began the work of bringing outstanding physicians and educators to Ohio's medical school.

In 1944, Dr. Charles A. Doan, chairman of the department of medicine and an authority on hematology, was appointed Dean of the Ohio State University College of Medicine

A view of University Hospital. Planned construction will bring wing at right (North Wing) to twelve stories.

(founded: 1914). And one by one, other eminent physicians were attracted to this growing medical college in Columbus, Ohio. Thus, in reverse of the normal order, a tradition of teaching, research and patient care became established at Ohio State years before the Health Center assumed its present potential in terms of its physical facilities.

Not until the war in the Pacific drew to a close were final plans worked out for the new Health Center. Yet, in the past ten years, bricks and mortar and equipment—twenty million dollars worth—have come together on the border of the Ohio State University campus. Nine integrated buildings have been constructed around a quadrangle dominated by the ultra-modern twelve-story University Hospital, a general medical and surgical hospital of 600 beds. And there's more to come. Additions to the University Hospital's north wing will include seven floors devoted to research activities at a construction cost estimated at five million dollars. Housing animal quarters, labs, animal operating rooms, x-ray facilities and related equipment, construction is expected to be completed in 1958.

Modern center

Of the nine Health Center buildings, four were built during the years 1948 to 1951. In the main building (University Hospital), the top seven floors are devoted to patient areas while the first four floors contain the service facilities of the hospital.

Twelve modern operating rooms,

a recovery room and a pathology laboratory occupy the entire fourth floor area of the building. The third floor is devoted to laboratories and the hospital pharmacy. On the second floor are the x-ray and physical medicine departments.

The hospital's first floor houses the administrative, business and admitting offices, medical records, medical social service, cafeteria, the university's cancer clinic, and the emergency room. The latter facility includes two large operating rooms and five treatment rooms.

Also located on the ground floor are the personnel department, kitchens and housekeeping service.

Hamilton Hall houses most of the pre-clinical facilities of the College of Medicine as well as the Center's library.

Starling-Loving building (formerly the 250 bed University Hospital) has recently been renovated and today contains the facilities for the outpatient department, the pathology department, and the School of Nursing. Visits to the outpatient clinics now total almost 100,000 yearly.

The Ohio Tuberculosis Hospital has a capacity of 300 beds for selected cases of diseases of the chest. Columbus Receiving Hospital, the Center's psychiatric facility, contains 140 beds for the care of acute psychiatric disorders. In addition, this hospital is organized as an institute of psychiatry. The Dental College's modern facility is also included in the Health Center's quadrangle. The remaining buildings house basic research laboratories for the department of medicine and the State Health Laboratories. Children's Hospital, a 250 bed pediatric hospital, is affiliated with the Health Center for teaching and research.

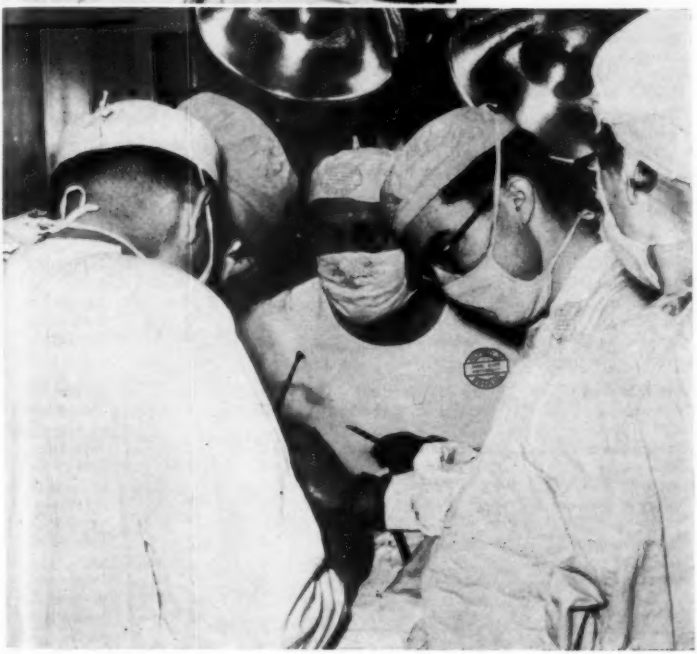
New equipment being installed is part of Center's current expansion program.

Organization

The Health Center is a unit of Ohio State University which is operated by the State of Ohio as a land grant university. In this regard, the Health Center has ready access to the varied facilities and disciplines of the University. Also, the University's IBM Computing Center is a valuable adjunct to many medical

Part-time and full-time attending staff men and chief resident in Thoracic Surgery discuss films with radiologist. Chest conferences are held weekly. Below, neurosurgery chief conducts rounds with house staff.

Residents are encouraged to pursue their own research projects. Here cancer research is undertaken, resident is injecting radioactive compound into tumor-bearing mice. Below, residents operate in one of the twelve modern operating rooms in the Health Center's well-equipped operating suite.



APPROVED RESIDENCIES
OHIO STATE UNIVERSITY HEALTH CENTER

SERVICE	CHIEF OF SERVICE	NUMBER OF RESIDENTS	LENGTH OF PROGRAM	PRE-REQUISITES
Internal Medicine	Bruce K. Wiseman	14	4	Internship
Allergy	John H. Mitchell	1	1	Intern and 2 yrs. Int. Med.
Cardiology	Ray W. Kissane	2	2	Intern and 2 yrs. Int. Med.
Dermatology & Syphilology	Eldred B. Heisel	Approval Pending		
Gastroenterology	C. Joseph DeLor	1	1	Intern and 2 yrs. Int. Med.
Hematology	Charles A. Doan	4	2	Intern and 2 yrs. Int. Med.
Metabolism & Endocrinology	George J. Hamwi	1	1	Intern and 2 yrs. Int. Med.
Neurology	Dwight Palmer	1	1	Internship
Physical Medicine & Rehabilitation	Ralph E. Worden	6	1 to 3 yrs.	Internship
Pulmonary Diseases (Non-Tuberculous)	John A. Prior	1	1	Intern and 2 yrs. Int. Med.
Obstetrics & Gynecology	John C. Ullery	12	4	Internship
Ophthalmology	William H. Havener (Acting)	10	3	Internship
Otolaryngology	Edward W. Harris	6	3	Internship
Pathology	Emmerich von Haam	8	4	Internship
Pediatrics	Earl H. Baxter	16	3	Internship
Preventive Medicine	William F. Ashe			
Aviation Medicine		2	3	Internship
Occupational Medicine		Approval Pending		
Pulmonary Diseases (Tuberculous)	Robert H. Browning	6	1 to 4 yrs.	Internship
Psychiatry	Ralph M. Patterson	21	4	Internship
Radiology	Sidney W. Nelson	12	3	Internship
General Surgery	Robert M. Zollinger	24	4	Internship
SURGICAL SUBSPECIALTIES:				
Anesthesiology	J. Jay Jacoby	19	2	Internship
Neurosurgery	Harry E. LeFever	2	3	Intern and 1 yr. Gen. Surg.
Oral Surgery	Morgan L. Allison, D.D.S.	5	2	Internship
Orthopedic Surgery	William S. Smith (Acting)	7	3	Intern and 1 yr. Gen. Surg.
Pediatric Surgery	H. William Clatworthy	2	2	Intern and 4 yr. Gen. Surg.
Plastic Surgery	Bruce C. Martin	4	2	Intern and 1 yr. Gen. Surg.
Thoracic Surgery	Karl P. Klassen	2	2	Intern and 4 yr. Gen. Surg.
Urology	William N. Taylor	6	3	Intern and 1 yr. Gen. Surg.

Students and staff of the medical illustration department prepare an exhibit. The department cooperates in the preparation of resident papers for publication.

research projects where there are mathematical or statistical problems.

The College of Veterinary Medicine assists the Health Center by providing animals and facilities for research activities.

Residents have the opportunity and are encouraged to pursue special courses of study leading to advanced degrees in the graduate schools of the university.

Medical staff

Appointment to the faculty of the College of Medicine is a prerequisite to consideration for an appointment to the medical staff of University Hospital. At the present time, the attending staff numbers 207 and the courtesy staff 156. Approximately 55 of the clinical teaching and research staff are "geographical full-time men."

Continued staff membership is contingent upon the member's will-

Resident Stipends

Junior Assistant Residents	$150
Assistant Residents	175
Senior Assistant Residents	225
Resident	250

Residents also receive laundry privileges.

Surgery Conferences

MONDAY

8 A.M.	Professor's Conference
9 A.M.	Chest Rounds, Staff
9 A.M.	Neurosurgery Rounds
11 A.M.	Chest X-ray Conference
12 NOON	Chest Cardiac Conference
1 P.M.	Neurosurgery Conference
3 P.M.	Staff Rounds
4 P.M.	History of Surgery

TUESDAY

9 A.M.	Neurosurgery Conference and Rounds
1 P.M.	Neurosurgery X-ray Conference
3 P.M.	Residents' Teaching Rounds
5 P.M.	Surgical Pathology

WEDNESDAY

9 A.M.	Orthopedic Conference Neuroanatomy
1 P.M.	Urology Conference
3 P.M.	Staff Rounds, Sophomore Students

THURSDAY

9 A.M.	Chest Rounds, Staff History of Neurosurgery
1 P.M.	Neuropathology
1:30 P.M.	Urology Conference—X-ray
2 P.M.	Neurosurgery Grand Rounds
5 P.M.	X-ray Diagnostic Conference

FRIDAY

9 A.M.	Neurosurgery Staff Rounds
1 P.M.	Urology Conference
2 P.M.	Orthopedic Conference
3 P.M.	General Surgery Staff Rounds
4 P.M.	Clinico-Pathology Conference
5 P.M.	Orthopedic Fracture Conference

SATURDAY

8 A.M.	Chest Staff Rounds
9 A.M.	Morbidity Conference
9:30 A.M.	Surgery Grand Rounds
11 A.M.	Tumor Conference

Shown as a representative service.

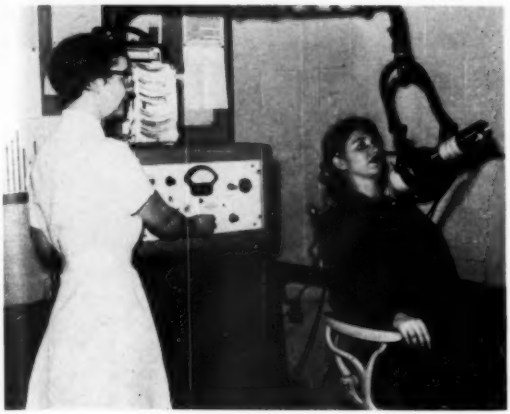
ingness "to be loyal to the concept of teaching."

Residencies

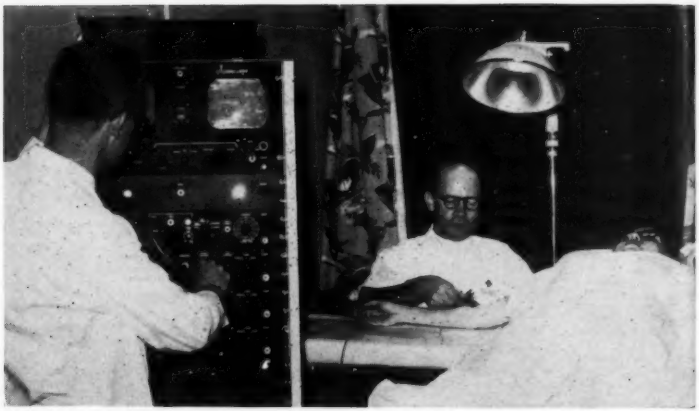
Residencies are approved in 27 specialties and subspecialties. Residents are faculty members of the College of Medicine and are entitled to the faculty privileges of the College and the University.

Teaching patients

University Hospital accepts both private and clinical (service) patients, the distinction being based upon patients' ability to pay, financial arrangements, and whether there exists a direct patient-private physician relationship. About half of the patients are clinical and half are private. About one-third of



Above, a scintillation spectrometer for patient thyroid uptake study at the Radioisotope Laboratory. Right, resident conducts an Electromyographic examination.



Brachial artery pressure is measured at the same time an EKG is recorded by electronic machine. Here a cardiology resident records seven tracings simultaneously.

Children's Hospital admissions are clinical patients.

In all hospitals every patient is a teaching patient regardless of the financial arrangement. A pamphlet, given to each patient at the time of admission, explains the Center's teaching philosophy.

Patients are segregated according to services; both clinical and private patients are located on the same nursing units and often in the same room with no distinction in the services provided. The Health Center adheres to a policy that conditions should "approximate as nearly as possible those which the intern or resident will meet in later practice, consistent, of course, with the provision of abundant teaching material." The resident, therefore, is able to become familiar with the economic and sociological problems in the private practice of medicine. In referring to this policy, Health Center officials point out: "It is a rare patient, indeed, either private or clinical, who does not enjoy the extra attention given him."

Under the supervision of the assigned staff doctor, the resident accepts senior responsibility for the care of the patient assigned to him. The assistant resident, intern, and medical student each performs his respective duties on the team headed by the resident. All members of the house staff team are called upon to exercise independence of judgment and responsibility commensurate with their experience.

Patients with unusual and special

diagnostic or treatment problems are referred to the hospital of the Health Center and to Children's Hospital where the facilities and staff are geared to cope with the unusual and the difficult. This is not done, however, to the exclusion of patients with the more common diseases. The resident is able, therefore, to gain experience in treating almost all the conditions which he is likely to encounter in later practice, proportionate to the incidence of such conditions. Some 75 percent of the patients admitted to University Hospital come from an area within a radius of 50 miles of Columbus, an area which has a population approximating 1,000,000. The remaining 25 percent of the Center's patients come from greater distances, out of state, and out of country.

Outpatient

University and Children's Hospitals both operate active outpatient services for medically indigent patients. Total visits to the outpatient services for the year 1956 were 96,000 and 39,000 respectively. Residents are assigned to supervise the work of fourth year medical students and to assume responsibility for seeking consultation as needed. Staff doctors are assigned to each clinic to supervise the teaching.

Emergency

Both University and Children's Hospitals maintain well equipped and active emergency departments. Visits at the University Hospital emergency room average approximately 70 a day. The emergency room is under the direction of the department of surgery for its professional activities, but residents from all specialties are utilized for consultations.

Conferences and rounds

Numerous conferences, rounds and seminars are scheduled for the house staff. Supplementing the resources of the Health Center are several other activities of note. During the year some 12 to 15 visiting professors in the various specialties will each spend a week or more in teaching activities at the Health Center. Travel clubs pay frequent visits and a number of national associations have held their national meetings at the Health Center.

Senior residents are sent to the national meetings in their specialty, usually in the company of senior staff physician. There is a genuine interest on the part of the staff that the resident become familiar with all aspects of medical practice including the economic, legal and social aspects.

Research

Active research is carried on in all the specialties of medicine. Numerous research grants support varied investigative activities as well as projects which are given less formal leadership by the senior per-

sonnel of the Center. The Dean of the College of Medicine and Director of the Health Center, Dr. Charles A. Doan, originally came to the University from the Rockefeller Institute for medical research with the appointment of Director of Research. He still retains the latter title and supports and sets examples in research activities which exemplify ideals of service to mankind. As pointed out previously, the Health Center is able to draw on the many resources of the University to lend depth and diversity to its research approach in solving medical problems. Research is likewise carried on in close association with the clinical and didactic activities of the Center.

Library

The Hamilton Hall Medical Library houses approximately 50,000 volumes and subscribes to 1,000 periodicals. Four branch libraries are operated in University Hospital and contain selected periodicals and volumes primarily for the use of the house staff doctors during their on-duty hours. Another such library is operated in Children's Hospital. The residents also have access to the main university library containing 1,500,000 volumes, and to all departmental libraries.

Associate teaching

Thirteen teaching programs in the associated health professions are integrated in the Health Center activi-

Before the House Officer begins training in July his family has a chance to become acquainted with other families at the annual house staff picnic.

ties. They include graduate professional nurses, professional student nurses, medical technology students, medical art students, dietary interns, and administrative residents.

Housing

A limited number of rooms are available to unmarried male interns and residents in the house staff quarters in Starling-Loving building. Since the Health Center is located in a residential area of Columbus, married house staff members experience little difficulty in locating suitable housing within the vicinity of the Center. A committee of the Intern and Residents Wives Club maintains listings and assists new house staff members in locating suitable housing.

Recreational and social

Residents are entitled to faculty preference for seating at the University athletic events, musical and theatrical programs. They are also entitled to the use of the swimming pool, tennis courts, and the many facilities of the new student union building. A club made up of the wives of interns and residents holds monthly meetings and sponsor other social events throughout the year. Several picnics and other events are sponsored during the year by the hospital and medical staff for the members of the house staff and their families.

In addition to the events at the University, Columbus offers many theatrical and concert performances, fine dining places, and other activities and places of special note. One administrator finds Columbus to be "a friendly city, kind of an overgrown town with most of the advantages of a large metropolis."

He who wishes to acquire exact knowledge of the medical art should possess a natural disposition for it, should attend a good school, should receive instruction from infancy, should have the desire to work and the time to dedicate to his studies."

HIPPOCRATES

Clinico-Pathological Conference

Ohio State University Hospital

A colored male, aged 48 years, was admitted to the University Hospital because of muscle twitchings and weakness of the lower extremities. He had apparently been in good health until about eight months prior to admission when his wife had noticed some jerking of his hands. At about the same time be began to drag his left foot while walking and from that time noted a very gradual progression of weakness in his left leg. Three months prior to admission he also began to notice somewhat less severe weakness of his right leg. A spinal tap done at this time by his local physician gave negative Wassermann, Kahn and colloidal gold reactions. He also began to notice weakness of his left hand (he was left-handed) and scattered fasciculations over the body from the shoulders down. The twitchings and weakness in his extremities were aggravated by any nervous excitement. Aside from some cramping in the left calf and posterior left thigh, no sensory changes were observed. There were no symptoms referable to any cranial nerves except some diminution in vision in his left eye for the past four to five years. A few months prior to admission the patient suffered a short, transitory dizzy spell. About 15 years prior to admission the patient was involved in an automobile accident which caused some small bruises of the base of the nose.

Physical examination

The patient was a well-oriented, intelligent and cooperative colored male who spoke and heard well. The head was of usual size and shape. The sclerae had a brownish tinge and bilateral arcus senilis was present. The lungs were clear to percussion and auscultation. The heart was not enlarged. There was a Grade

II systolic murmur at the apex and Grade II systolic and diastolic murmurs were detected in the tricuspid area. The heart sounds were very faint in the pulmonic region, while a Grade I to II systolic murmur was audible in the aortic region. Examination of the abdomen, genitalia and rectum showed no significant changes. The extremities appeared symmetrical and without deformities; the pulse was palpable on the dorsums of both feet.

The neurological examination revealed the following: Examination of the eyegrounds showed a very white left disc and a normal right fundus. His right pupil reacted to light; the left pupil did not react to light directly but only consensually. His vision in the left eye was very poor, while the visual field of the right eye was within normal limits. The ocular movements were normal. Examination of the other cranial nerves revealed no significant changes.

The left upper arm was weaker than the right and fasciculations were seen in the left forearm. There was about equal weakness of both legs and many fasciculations could be noted in both thighs. No muscular atrophy was present. Examination of the sensory nerves revealed no abnormalities. Examination of the cerebellar function showed that the patient walked with the thorax bent slightly forward and with a wide base. The patient could walk looking up. The position sense of the toes was normal. There were also normal finger-to-nose and finger-to-finger, pronation and supination movements. The Romberg sign was positive. All peripheral reflexes were active and the knee and ankle reflexes were hyperactive. The Babinski reflex was positive on the right side and questionable on the left. There was also a 1 plus Chaddock's sign on the right. Bladder and bowel functions were regular. Neurological examination was repeated with essentially the same findings later except that one observer mentioned bilateral optic atrophy which was more marked on the left than on the right.

Laboratory findings

His peripheral blood counts and hemoglobin were within normal range. The examination of the urine revealed many WBC and a moderate amount of epithelial cells. The thymol turbidity test was 10 units. Examination of the spinal fluid revealed no globulin, WBC or RBC, and a protein content of 110 mg. His blood Wassermann was positive; his spinal fluid serology was negative. A repeat blood serology again revealed a positive Wassermann reaction, a quantitatively negative Kahn test, and a positive VDRL. The colloidal gold reaction of the spinal fluid gave a first zone curve.

Roentgenographic

The heart measured 14.4 cm. in transverse diameter from the wid-

est point on the left side to the widest point on the right, which represented the upper limit of normal value and could mean a 10% enlargement of the heart. There was no enlargement of a specific chamber.

The aorta was of normal caliber, the arch was not dilated, and there was no evidence of calcifications of the ascending portion. The lung fields appeared normal.

Hospital course

The patient received 1.2 million units of penicillin intravenously per day. A few days after treatment was started the patient stated that his joints were loosening up but later complained of stiffness in the neck and shoulders. The patient felt that he had more power in his legs. The fasciculations were definitely less intense than on admission. The patient was slightly improved when discharged after the administration of 15 million units of penicillin but further follow-up in the outpatient clinic was recommended.

On his first visit there the findings were essentially the same as during his stay in the hospital; the fasciculations in the arms and legs, weakness in hands and legs, and spasticity of the legs persisted. The patient had become practically blind in the left eye. Treatment with potassium iodide and nicotinic acid was recommended. Two months later muscular atrophy of both hands was noted which was more severe on the left side than on the right. One month later the patient again showed a progression of his neurological symptoms; his speech had become somewhat slurred but he had no difficulty in swallowing; the spastic condition of his muscles persisted. A blood serology repeated a few months later revealed a negative Wassermann and Kahn and a positive Kline.

When the patient appeared at the clinic four months later it was noted that his condition had become worse although his euphoria prevented recognition of his increasing disability. The paralysis of the left arm and leg was increasing, accompanied by increasing disability in his right arm so that he was almost unable to feed himself. His speech was markedly slurred. Five months later the patient's speech had deteriorated and he was quadriperetic. All reflexes were exaggerated and there was some urinary urgency but no incontience.

The patient was treated with amphetamine and tolserol. Eighteen months after his discharge from University Hospital the patient appeared totally disabled and was admitted to an asylum. His condition did not change there and no specific therapy was instituted. Some months later he developed a fever and rales over both lungs. He was treated with antibiotics but expired a few days after the onset of this final episode, three years after he was seen in University Hospital.

Clinical discussion

Dr. W. E. Hunt: This is the case of 48-year-old colored male who was admitted to the University Hospital because of muscle twitchings and weakness of the lower extremities. He also noted scattered fasciculations over the whole body from the shoulders down and at the same time he was beginning to have difficulty with his left leg. His right leg became involved somewhat later and then his left hand. We have thus a steady progression of his nervous symptoms which did not follow the standard progression of ipsilateral arm, ipsilateral leg, contralateral leg, contralateral arm—the one, two, three, four signs of a brain tumor.

The very vagueness of his specification as to the progress of his difficulties may be of diagnostic value, and it may also indicate that the progress was not very clear-cut.

Because of his fasciculations we should immediately become alerted to the concept that this may be a lower motor nerve lesion or some metabolic disturbance in which the lower motor neurons are involved.

We were struck by two strong negatives in this history: one is the absence of pain and the other is the absence of any sensory changes. Both of these are of the greatest importance in the diagnosis of somebody whose neurologic functions are beginning to fall apart. His Romberg was positive and this is the first sign we have of some sensory disturbance. This and the presence of a gait with a slightly widened base could lead us to believe that he would have some impairment of the posterior column sense. Specifically a Romberg is only classically positive when the sway is markedly exacerbated by closing the eyes. This implies that the patient steadies his equilibrium by means of his visual apparatus. If he just sways, eyes open or eyes closed, it is not a positive Romberg. His increased reflexes and his positive Babinski and Chaddock are pyramidal signs, while his fasciculations mean that his lower motor neurons are not working properly. His laboratory tests were all essentially negative except for his positive Wassermann.

The examination of his spinal fluid indicates that it contained an abnormal protein fragment, which probably was a globulin. The x-ray examination of the chest admitted the possibility of a syphilitic aortic valvulitis but gave no evidence of a leutic aortitis. The course of the disease was a long one and most of it took place after he was discharged from the hospital.

A vigorous antiuetic penicillin therapy was instituted and he complained of stiffness about the neck and shoulders. This we regard as the first subjective sign that fits into our always present suspicion of a surgical lesion in the high cervical spine which is simulating a degenerative or diffuse disease of the spinal cord. After all, the important problem in dealing with any diffuse

disease of the spinal cord is the exclusion of all conditions which are amenable to surgical treatment, since the so-called "medical" diseases of the cord notoriously resist any therapy. After a slight improvement following the administration of 15 million units I.V. of penicillin the patient was observed in the Outpatient department. His condition became steadily worse and 18 months after discharge from the hospital the patient was totally disabled and had to be admitted to an asylum. There he expired after a brief episode of fever and signs of a respiratory disease.

Sclerosis

From the story it is obvious that the patient had the syndrome of upper and lower neuron paralysis which was progressive, somewhat asymmetrical, unassociated with pain but associated with blindness and syphilis. I think we can safely make the diagnosis of an amyotrophic lateral sclerosis syndrome because he suffered from amyotrophy as evidenced by muscular atrophy and fasciculations, and lateral sclerosis as evidenced by his spasticity and a Babinski sign. He also suffered from blindness, which is pertinent in raising the suspicion that his disease was not the typical idiopathic amyotrophic lateral sclerosis.

We think of syphilis, of course, and of multiple sclerosis. In multiple sclerosis we rarely observe fasciculations and the neurological symptoms are not systemic but spotty.

Lues of the spinal cord causes a spastic diplegia which usually leads to early difficulties with the bladder. His disease progressed after vigorous therapy instead of becoming stabilized.

There is another lesion which has been attributed to syphilis but which in the more recent literature is being classified as an idiopathic condition, and that is cervical hypertrophic pachymeningitis. In this disease the thickened dura compresses the cervical spinal cord and gives an amyotrophy — like syndrome with lower motor neuron paralysis in the upper extremities and a spastic paraplegia in the lower.

Tabes must also be considered, of course. I think we must accept that he had a positive Romberg sign, but that is the only clinical evidence we have for the diagnosis of tabes.

We also must consider a spinal cord tumor, a dislocated disc and congenital malformations of the upper cervical spine and the base of the skull in our differential diagnosis.

All these conditions may give symptoms which stimulate amyotrophic lateral sclerosis and which keep up our hope that we may be able to find a disease amenable to treatment.

Yaskin in Philadelphia presented a patient for six years to his students as amyotrophic lateral sclerosis until he realized that the pa-

tient had lived too long for this disease. He found that the patient had platybasia. Our patient could also have a basilar tumor in spite of the fact that he had no pain or suboccipital numbness. He also had no atrophy or fasciculations in his tongue.

The appearance of his bulbar signs rules out the presence of a dislocated disc and any malformation of the bones of the base of the skull. I suppose it is conceivable from the development of his symptoms that he may have had an axial tumor, but we know one thing for sure: that this man had a disease of his big motor cells. He was fasciculating in his legs, which means that the anterior horn cells clear down to the lower end of the cord were diseased. He also had an increased jaw jerk and sloppy speech, and I cannot state with certainty whether the weakness of his bulbar musculature was entirely due to lower motor neuron disease or whether it was due to upper and lower neuron disease.

Amyotrophic lateral sclerosis is not a disease of anterior horn cells and lateral tracts. Amyotrophic lateral sclerosis is a disease of the big motor cells and therefore we observe muscular atrophy with fasciculations from the diseased anterior horn cells and the lateral sclerosis syndrome from the diseased motor cells in the cerebral cortex. Our patient fits this concept on a somewhat atypical basis. For this reason my diagnosis of this case is that of amyotrophic lateral sclerosis, unrelated to his syphilis, although I am disturbed by his unilateral optic atrophy.

I also believe that this patient has not been completely worked up because he never had cervical spine films and it is quite possible that a high cervical myelogram might have discovered something that we could not otherwise know about.

Clinical discussion

Medical Student: Could he have had both a tumor and amyotrophic lateral sclerosis?

Dr. Hunt: He could have. We then deal with the problem of two rare diseases occurring in the same individual.

Medical Student: Could a disturbance of his calcium metabolism cause the fasciculations?

Dr. Hunt: Probably not. About the only thing that will give you generalized fasciculations of any note, except in somebody who is getting ready to have a hypocalcemic convulsion, is thyrotoxicosis, and that will produce a diffuse muscular atrophy and wasting and with a high BMR, but those patients don't have lateral column signs.

Medical Student: Did anybody do a Queckenstedt?

Dr. Hunt: No, and I must criticize this severely. This patient, in spite of my primary diagnosis, should be suspected of having a surgical lesion and we simply cannot make a differential diagnosis without a Queck-

enstedt and x-ray studies in a syndrome like this.

CLINICAL DIAGNOSIS:

1. Amyotrophic lateral sclerosis.
2. Terminal bronchopneumonia.

PATHOLOGICAL DIAGNOSIS:

1. Amyotrophic lateral sclerosis.
2. Craniopharyngioma of sella turcica with compression of the base of the brain.
3. Bilateral optic nerve atrophy.
4. Acute bronchopneumonia.

Pathological discussion

Dr. E. von Haam: The body was that of a well-developed, well-nourished colored male. All muscles of his upper and lower extremities showed advanced atrophy. The majority of those muscles were reduced to fibrous tissue with little red muscle tissue remaining. The heart was not enlarged. The mitral leaflets appeared thickened, the tendinous cords were thickened and fused. The aorta showed minimal arteriosclerosis. Both lungs showed confluent areas of patchy consolidation, the larger bronchi contained pus. The remaining organs were small but otherwise appeared normal.

When we opened the skull we found a rather large tumor arising from the sella turcica. It seemed to completely obscure and compress the pituitary. The tumor was nodular and invaded the bony structures of the sphenoid bone. It destroyed the left olfactory nerve and pressed heavily on the optic chiasm. It had produced an excavation at the base of the frontal lobe. The brain weighed 1270 gm. The oval defect produced by the tumor extended from the base of the left frontal lobe to the mammillary bodies. The brain tissue surrounding the defect was atrophic; otherwise the hemispheres revealed a normal convolutional pattern. The spinal fluid was slightly increased in quantity and was clear. The optic chiasm was paper-thin. The spinal cord revealed no gross pathology.

Microscopic examination

Sections through the heart and aorta showed no evidence of lues. Sections through both lungs showed extensive recent bronchopneumonia. Sections through the tumor revealed nests of cells which resembled transitional epithelial cells and which we considered as typical of craniopharyngioma. These tumors are derived from the midportion of the hypophysis, a remnant of the Rathke pouch. They are either cystic or solid and may be intrasellar or suprasellar tumors. They are usually benign although a few are malignant.

They are more frequent in children than in adults and represent about 4.1% of all intracranial tumors. Sections through the brain showed compression atrophy of the cortex of the base of the frontal lobes. There was no evidence of

ues. Sections through the spinal cord at various levels showed severe degeneration of the ganglion cells of the anterior horns with great diminution in the number of cells. The lateral tracts of the cord showed advanced myelin degeneration.

The picture confirmed fully the clinical diagnosis of amyotrophic lateral sclerosis. The posterior tracts were not affected. Sections through the muscles of the leg showed severe atrophy of neurogenic type with some inflammatory changes and without pseudohypertrophy.

In summary then we can state that the patient suffered from amyotrophic lateral sclerosis and a craniopharyngioma of the sella turcica which exerted pressure on the base of the brain.

He died from acute bronchopneumonia probably the result of respiratory difficulties encountered during his spinal cord disease.

The craniopharyngioma was of the benign type and could have been in existence for some time. It undoubtedly was responsible for some of his symptoms. I would like to commend Dr. Hunt for the fact that he strongly suspected the presence of some other lesion which complicated the spinal cord disease although he could not decide as to the nature of this lesion. I would like to ask him whether he considers possible any causal relationship between the basal skull tumor and the patient's spinal cord disease?

General discussion

Dr. Hunt: I don't believe I deserve any congratulations because I was not thinking of a tumor of this type or in this location. I was thinking of a tumor along the base or at the medullospinal junction accounting for his spasticity and quadriparesis. His optic nerve atrophy we referred to several times and then proceeded to abandon as a red herring and conceivably due to syphilis. I dare say the increased spinal fluid protein was due to the tumor. The patient died from his amyotrophic lateral sclerosis and not his tumor.

How could we have recognized both conditions?

In retrospect, by a more thorough discussion of every single neurologic sign he had, which I neglected to do.

During the patient's life his condition could have been recognized by an x-ray of the skull and determination of the visual fields. The visual fields would have shown either a nasal or a temporal homonymous hemianopsia and skull x-rays would unquestionably have shown the sellar changes. At the base of the brain, the base of the skull, and in the high cervical spine neoplasms may produce symptoms simulating degenerative disease, without increased intracranial pressure, and are hard to diagnose.

If you have any questions with regard to the relationship of these diseases of our patient, I think that there is little doubt, from Dr. von

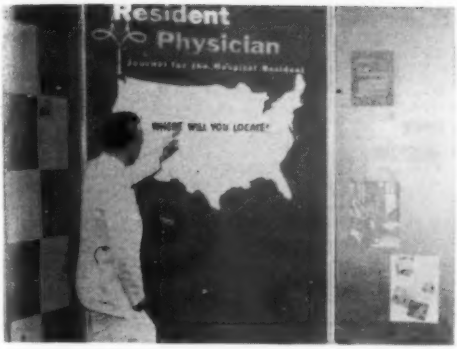
Haam's report, that we are dealing with two separate diseases.

Dr. Jack Widrich: Should the patient have been showing signs of pituitary deficiency?

Dr. Hunt: It does not take much pituitary tissue to preserve its function. There is no comment as to whether or not he was impotent and of course his general health could easily have been used to explain that.

Medical Student: If you had recognized his cranial tumor during his life, would you have recommended surgery?

Dr. Hunt: No. He certainly had the classical amyotrophic syndrome and would have had no chance to survive.



An Invitation

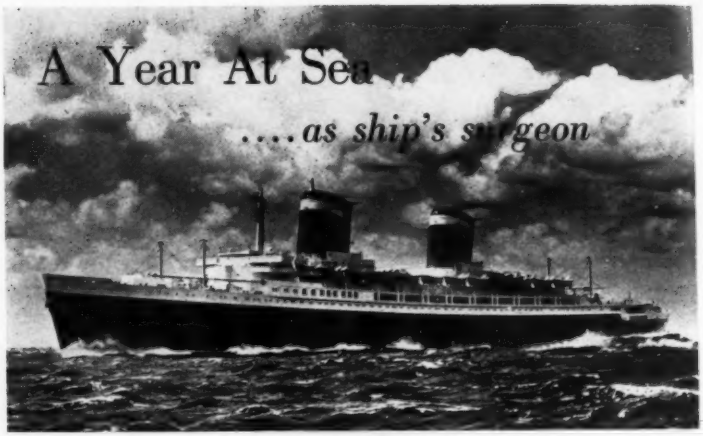
. . . I hope all residents and interns attending the annual meeting and convention of the American Medical Association in New York City, June 3 to 7, will take a moment to visit with us at the Resident Physician exhibit. Located at Booth A-8 on the main floor of the New York Coliseum, we will be on hand to discuss any comments or suggestions you may have concerning your journal.

For your convenience in getting off a quick letter home, we will have available a free stenographic and typing service at our exhibit location.

Please stop by and get acquainted.

Cordially,

Perrin H. Long.



If you can qualify for a ship's surgeon job on one of the many U. S. passenger ships, you'll be paid for an ocean cruise. But there are few openings, many applicants. The key, says the author, is persistence.

William Dvorine, M.D.

I suppose most residents have heard tell of the wonderful excursions of seagoing physicians. These shipboard medics, usually referred to as ship's surgeons, are often the envy of landlocked doctors. And I imagine many of you have at some time or other considered looking into the situation with a view to spending a few months on an ocean cruise to exotic lands and tropic climes.

Yet, somehow, you put it off. And, in many instances, I think you have made a wise decision.

Taking time out for a job as ship's surgeon can be a complete waste of valuable time, a needless postponement of your residency training or private practice.

But, there are valid reasons for seeking an opportunity as a ship's doctor, two such I enumerate herewith:

1. You're broke. You've finished your residency but need some cash in order to open up your office.

2. After your internship or two or three years of residency, or at the end of your residency, you find

yourself completely beat. Physically and mentally.

Tired of hospitals, hospital whites, irregular hours, near poverty, and under constant strain for a long period, you're looking for an absolute break from your hospital routine.

If you can combine both of these reasons and apply them to your present situation, so much the better (or worse?) as far as your being a suitable object for a free vacation.

But dry your tears. I will attempt to give you a complete account of how to go about getting a job as a ship's surgeon and what you may expect in the way of work, vacation and salary if you are lucky enough to be signed on one of the passenger vessels flying the U. S. flag.

Top jobs

Currently there are about 80 ship's surgeon posts on U. S. passenger and passenger-freighter liners. Some of these are top jobs, filled more or less permanently by long termers.

But the majority of physicians who ship out on liners don't make a career of this sea-going work. Vacancies do show up fairly frequently.

There are two basic reasons for the turnover. First, these big boat rides are no picnic. An "epidemic" of mal de mer is generally followed by slips and falls and broken bones. A "bad crossing" can mean a load of work for the ship's surgeon.

Secondly, most ship's surgeons are residents like yourself. They're not permanently fascinated by deep sea surgery any more than you would be.

Tired

To show you first how I got involved in this salty fraternity, I'll sketch my own background leading up to twelve months of surgical sea duty.

About halfway through my internship I contracted infectious mononucleosis. By the time the end of the year rolled around, I had my fill of hospitals—and still hadn't decided on the type of residency I wanted to enter. Besides, I was just plain tired. (I think this gave me a somewhat warped and sour view-

About The Author

A graduate of the University of Maryland Medical School in 1955, he interned at Sinai Hospital, Baltimore, Maryland until June, 1956. It was at this time that the author began the 'saga of the seagoing surgeon' described in this article. In January of this year he entered a residency (dermatology) at the Veterans Administration Hospital, Manhattan, New York City.

point on many things.) Anyway, I wanted a change; but unfortunately I was in no financial position to take off on any kind of a vacation.

This situation led me to look for some form of work that would be medically stimulating, physically easy, and if possible, with good remuneration.

A few practicing physician friends told me of their experiences while working aboard ocean liners. Most of them had done this following their residency. From their conversations I decided there was only one thing for me to do—try to go to sea as a doctor.

Applications

The first thing I did was write for information to all the large steamship lines. Most of them answered promptly. Some were indefinite and a few related that they had no need for physicians at the time but sent me an application for my name to be placed on file. I was told I would be contacted in the near future if an opening presented itself.

The remainder replied that they had permanent physicians aboard their ships or no present need and did not send applications.

I sent three applications for my name to be placed on file, all to New York City. When a month passed and I heard nothing, I travelled to New York to see what chances there were for me. This was in March.

I called and received an interview with one medical director who astounded me by offering a position at once on a large ship; the regular doctor was ill. Unfortunately, I had not yet completed my internship and was not qualified to sail. The director said he would place my name on file for future reference.

At another office I spoke briefly to a secretary as the medical director was out. She told me it was too early to know if there would be an opening in July. She suggested I contact them in a month.

At the third company I was told flatly by the director that there were no vacancies in the near future but I would be called if anything came up.

Incidentally, the companies usually leave the arrangements for the interview (very important) up to you. They will not call; it's on your own initiative that you will get an appointment.

Interview

I corresponded during April and May with the one company that had instructed me to keep in touch with them. Each time I received the same reply: "Too soon."

By June I was getting a little anxious; I had nothing to look forward to after July 1st. I called the company and asked for an interview with the medical director. This was granted and I journeyed again to New York. In a three minute interview I was hired with an

added fatherly warning: "You'd better behave yourself."

Regarding the interview with the medical director, my advice is to let *him* ask the questions. The one thing you must do is make him feel that you mean business. You want to be a ship's doctor more than anything else and you will work for at least six months.

Most of these directors are very friendly. They have been to sea and know what the life is like. You will be chosen on the basis of your general appearance, ease of manner, past record and letters of recommendation. If you are hired, however, the acid test is your first trip. The director will get a report from the captain on your conduct, efficiency, and general activity. If you have not been alcoholic, or too obviously a playboy, the report will be favorable and you will have it made.

Incidentally, I never heard from any of the companies that said they would "place my name on file." If you want the job you have to go out and get it. It will not come to you, if you know what I mean.

Maiden voyage

My first trip was six weeks to South America on a freighter carrying 50 passengers and a crew of 80. I had a small, air conditioned, inboard stateroom. It was very nice. There was a dispensary-hospital in the after part of the ship for the crew. Passengers were seen in their rooms. There was no nurse aboard; I did all the paperwork. I saw an average of three patients a day, mostly crew.

I must have been a success on my first trip because I was promptly offered a place on a 225-passenger cruise ship carrying a crew of 180. In this ship I had a large cabin adjoined by an office for passenger patients only. On the next deck below, was the dispensary, operating room and eight-bed hospital. I saw about ten patients a day, equally divided among passengers and crew. There was a nurse too, which made the work much easier. Recreation included a swimming pool, gym,

The author found enjoyable hours of leisure and sun at the ship's pool.

dancing every night, recent movies, and parties.

I worked for the company for almost six months. My reason for leaving was that a very good residency in my chosen field presented itself somewhat earlier than I had expected. Otherwise, I would still be at sea. The food was wonderful, the work usually easy and always interesting, the pay good, plenty of sleep and fresh air. I loved every minute of it.

Apply now

Apply whenever you get the urge; now, before you change your mind and miss out on a worthwhile adventure. It would be best to apply a few months before you are actually ready to sail.

Almost all of the large steamship lines have need for doctors from time to time. Foreign companies rarely, if ever, hire American physicians. Also, their pay scale is much lower. Your best bet is to stick to the American companies. These include Grace, Panama Lines, American Export Lines, Moore-McCormack, United States Lines, American President Lines, Delta, and Matson.

Any American ship carrying more than 12 passengers must have a physician on board; therefore, there are a good number of openings. Applications should be sent to: *Medical Director*, care of the home or main office. Addresses for all companies can be found in the travel section of the Sunday edition of the New York Times, The New Yorker Magazine, Holiday Magazine, or from travel folders.

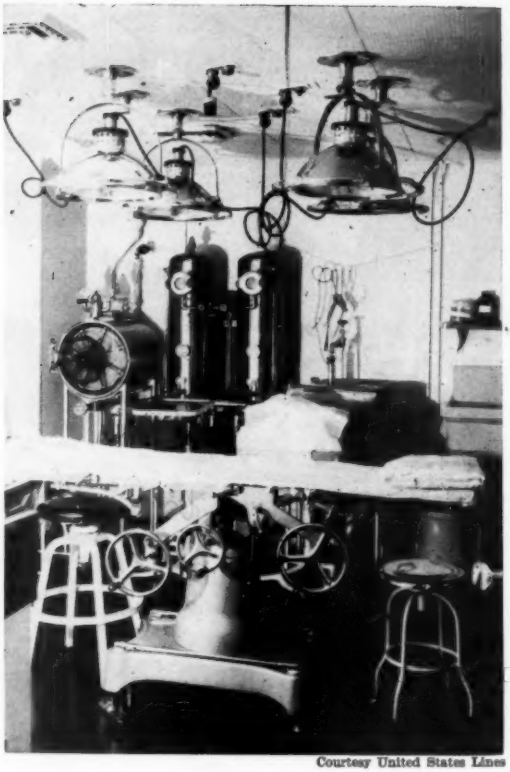
Requirements

Some of the companies require one or two years of surgical residency. However, it would be wise to inquire concerning this point as they will hire physicians without formal surgical training if they cannot get those with it.

To sail as a ship's surgeon you must be licensed by the U. S. Coast Guard. The license can be obtained at any Coast Guard headquarters, usually located in the larger coastal cities. You must bring with you at time of application the following:

1. Original medical school diploma (no photostats accepted)
2. Original license to practice medicine in any of the 48 states or District of Columbia.
3. Birth certificate.
4. Naturalization papers, if naturalized citizen.
5. Certificate or proof of one year of internship.
6. *A letter from a steamship company declaring that you are to be employed as a Ship's Surgeon.*
7. Two letters from practicing physicians attesting to your moral character and professional ability.
8. Five small passport size photographs.

From the above it is evident that you must get your job before you

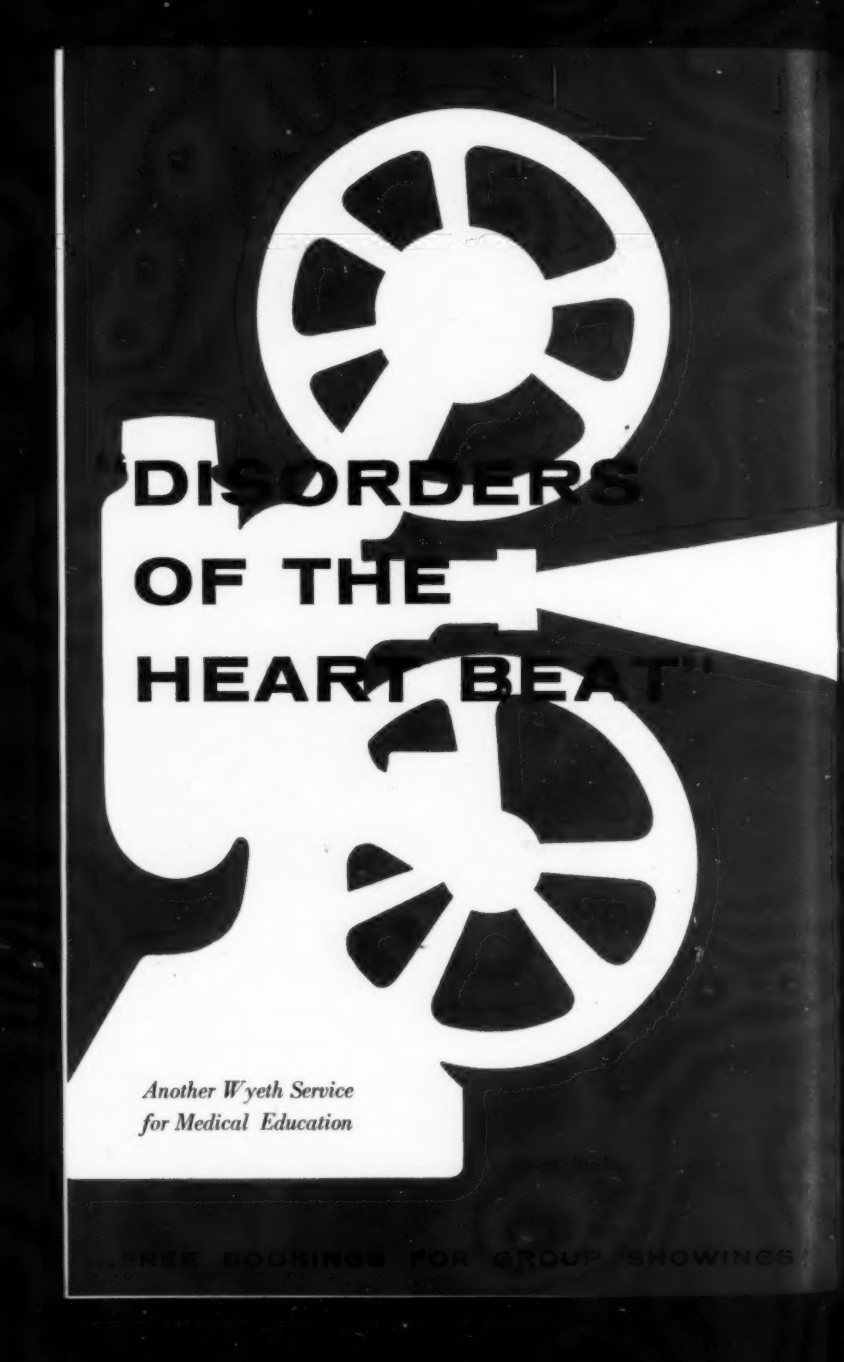


Courtesy United States Lines

Gleaming new operating room offers the ship's surgeon a modern facility for emergency surgery. No elective surgery is permitted on board ship—and even emergency cases are taken by Coast Guard helicopter to U. S. hospitals whenever the ship's location will permit.

can get your license. It takes about 30 days for your application to be processed. At the end of this time you will receive your license as a ship's surgeon and a "Z" or seaman's identification card. The latter is "validated for emergency service" which means the FBI has cleared you after investigation. The license and the card comprise your merchant marine documents (MMD). Both of these should be in your possession at all times once you receive them and while you are sailing.

In South America a passport is not necessary but may be helpful if you get in trouble with local police or customs. Usually the "Z" card is all that is needed to estab-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lish your identification. If your ship touches ports in Europe, Africa or Asia it would be wise to have a passport. Remember, it takes somewhat longer for passport processing than for your seaman's documents.

If your merchant marine documents are not cleared by the time you are to sail, the company can get a temporary permit for you. This will enable you to make one trip and your documents will be waiting for you when you return.

Vaccination for smallpox is required by law. It is good for 3 years. Make sure you carry the certificate of vaccination with you. Do not be placed in the embarrassing position of being the only one without proof of vaccination when all on board are screened by the Public Health physician when the ship reaches home port. Typhoid and tetanus immunization would be a wise procedure. The company may suggest other inoculations depending upon the areas to be visited by the ship.

No contract

When you are hired by a company there is no contract signed. Most companies would like to feel that a gentleman's agreement exists that you will work for a minimum of three months. If they do not like your service you can be dropped at any time. Likewise, if you suffer from severe mal de mare you may voluntarily resign. Each time you sail, or every few trips depending on the length of the voyage, you will "sign on" as the surgeon. One company, the Panama Line, signs on a new doctor for each voyage, usually lasting a couple of weeks. No uniforms are needed and it is a good deal for just a yearly vacation. The waiting list is a long one.

The very large ships have a permanent surgeon, a career man at sea. There are openings from time to time for assistant surgeons. However, all but the very large ships carry just one doctor. The large liners also have permanent and temporary nurses. The latter, as nurses on other ships, are hired for a period of three months.

Uniforms

On ships requiring uniforms you must supply your own. These include at least three white Navy dress, 1 set Navy blues, cap with white and blue covers, one white mess jacket and formal trousers, cummerbund, black tie, black shoes and white shoes. A few khakis, bathing suits, white Dacron shirts (easy to wash yourself) and a minimum of civilian clothes and you are ready to travel. Make sure you find out what kind of climate you will be experiencing. Remember, seasons are reversed in the southern hemisphere. Uniforms will cost about $120. If you know someone with old Navy uniforms you can save yourself some money. (It's not easy, if at all possible, to buy them on the installment plan.) The com-

pany will supply all insignia and buttons. Large ships having a laundry will do your clothes at your own expense, usually no more than a few dollars a month. On small ships, you will have to wait for port or do your own.

All medical equipment on board ship is supplied by the company. You can leave your bag at home although it's a good idea to bring your own stethoscope. The Merck Manual and a book on minor surgery and fractures will be useful, also the Physicians Desk Reference to decipher an obscure drug a passenger has lost.

Steamship lines prefer single men. They will hire married doctors *but the wife cannot travel on board even if she pays for passage.* It's rough, but that's the way it is. As I think back on many pleasant memories, I can see more than one reason for the rule.

Before you sail you will have to sign on. This requires your presenting your license and "Z" card to the Coast Guard officer on the pier and signing the "Ship's Articles," or official crew list. The Coast Guard keeps careful records of who sails when and where. Be sure that you sign on, otherwise you will not be paid. The company's medical department will inform you of the time and place. They will also give you a booklet describing rules and regulations, sample accident and illness forms, and instructions for keeping records. This is a very valuable and useful document and you will refer to it quite often.

If you are fortunate enough to secure a position you will find that medicine aboard ship is like general practice. Anything can happen. Most of the people on board will be healthy, and you will not be very busy. In rough weather, however, things may get hectic. Fractures, sprains, dislocations, and

Foreign ports provide interesting excursions. Pictured is Curacao, Netherlands West Indies.

lacerations may be numerous.

The medical stores and equipment aboard ship are usually very complete and up to date. Medical supplies are requisitioned at the end of each voyage.

If there is any medication not on board which you would like to have, order it. You will usually receive it.

As mentioned previously, larger ships carry two doctors and several nurses. On medium size vessels you will be the only doctor along with one or two nurses. But passenger-freighters normally do not carry nurses. The stewardess or chief mate will serve as your assistant, if necessary.

Ample surgical instruments and operating facilities are present on all but the smaller ships. These are primarily for emergency use. Needless to say, no operations are performed at sea that could wait for the ship to reach port. If near the coast of the U. S., a Coast Guard rescue plane will fly a seriously ill patient back to the mainland. No elective surgery of any nature is ever done at sea. Crew members are referred to the Public Health Service and passengers to their own physicians or the medical director.

In a real emergency, there is almost invariably a vacationing physician aboard who can be called upon for assistance.

Office hours aboard ship are usually twice a day. There are separate times for passengers and for crew. Emergencies and night calls are taken care of immediately. Minor cases can be seen by the nurse. However, you must see the following:

1. Any illness or injury requiring a report.
2. Any case of venereal disease.
3. Any case in which a crew member must be relieved of duty.
4. Any case requiring a detailed examination or treatment.

Crew members should be seen only in the dispensary and not in your office which is meant for passengers. I once made the mistake of seeing a staid old Boston lady and a dirty greasy oiler in my office at the same time. The repercussions were terrible.

Records

Medical records are extremely important. They are your responsibility. Log notes should be complete and detailed. Entries should be made for all passengers and crew members seen. Accident reports should be made on all cases. Illness reports should be filed on all but minor cases. It is better to make up reports unnecessarily than to forget to document a case that could come up in court later on. Even though I am not sailing at present, the claims department of the company calls me from time to time for information concerning claims filed by seamen for past illnesses and accidents. I am glad I

have good log notes and reports to refer to.

Fees

Your salary will be about $500 a month. Most companies allow you to charge for services rendered to passengers in cases of illness or chronic disability *which existed prior to embarkation*, and for which the vessel is in no way responsible.

Any illness or injury which is contingent upon the navigation cannot be charged for. However, if any illness or injury results from overindulgence, the surgeon is permitted to charge the usual fee. These fees average the following:

1. Call to cabin	$3.00
2. Call to office	$2.00
3. Minor surgery	$10 to $50
4. Major operations	$100 to $200
5. Embalming	$75

All statements for professional services must be approved by the captain. It is his decision as to payment when a dispute arises should a passenger feel a fee is too high. The purser will collect fees for the surgeon if statements are submitted to him 24 hours prior to arrival at port of embarkation.

The surgeon is not permitted to charge any officer or member of the crew, nor to charge for smallpox vaccinations.

Some companies do not permit the surgeon to charge for any service. Many people, however, will return courtesies in the form of gifts, champagne, and so forth.

For crossword puzzle addicts, boy of Cartagena, Columbia, S. A., holds a favorite crossword subject: three-toed sloth.

The nurse is responsible for maintenance of the dispensary and hospital, sterilization of linen, instruments. She will also order medical supplies, and type all medical records. She will keep an inventory of all equipment and supplies.

Social

Your social obligations vary according to the individual policy of the steamship company. For example, one large company instructs its surgeons in the following manner: " . . . it is to be remembered that the surgeon's primary respon-

sibility is to care for the health of passengers and crew members while at sea, and that any social entertainment of passengers is of secondary importance . . . it is strongly advised that the surgeon should not entertain his guests at the bar or in public rooms with cocktails or alcoholic drinks of any type. . . . "

Many companies allow the surgeon a generous allowance for entertainment. A great deal depends on the captain. It would be wise to find out his feelings on this matter. I found that strictly social drinking is permissible if not carried to excess.

As ship's surgeon you will be involved in other social activities. You will have your own table in the dining room with several selected passengers. As you examine vaccination certificates when passengers board the ship you may be able to pick out some pleasant people to dine with. Otherwise, you will have several middle-aged women seated with you.

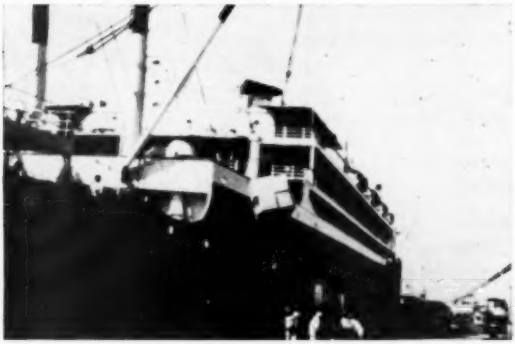
In the evenings you are expected to mingle freely with all passengers. You may dance but do not expect to monopolize the very attractive women for long (the captain also mingles). Incidentally, if you are the only surgeon on board, you have the same three-stripe rating as the chief mate, chief purser and chief steward. Only the Captain and chief engineer are four stripers. As an assistant surgeon you will have two stripes.

Sometime during the first 24 hours you will report to the captain, or as he is officially designated, the Master. Saluting is not necessary at any time. Introduce yourself and you will then hear what he expects of you. If he does not cover all matters such as use of swimming pool, drinking, shore leave, daily reports, and so forth, you may bring these matters up, *tactfully*. As Master, his word is law. Aboard ship everything is his responsibility. Keep him well informed of all accidents and illnesses. Sea captains are a group apart; many are friendly, intelligent and stable individuals, many are not. For general purposes:

1. Do not try to get chummy with the captain. Let him take the initiative. Treat him with respect and follow his instructions faithfully. He can bounce you off his ship if he desires (on land of course).

2. Stay away from any women he has his eye on. Never, *never* cut in on him on the dance floor.

3. Never take problems directly to him. See the purser or chief mate first, for advice. They are usually very helpful. Even if the "Old Man" is wrong, don't contradict him. Let the purser or mate handle the situation. They have been sailing with him longer than you have and know how to handle him.



Freight loading operations, a spectacle in itself.

4. Stay out of the captain's way when coming into or leaving port. When the pilot is aboard, the captain is fully occupied.
5. Stay off the bridge unless invited.

I remember one incident; it concerned a parrot. A lady arrived on board with a beautiful bird. It seemed healthy and the required papers were in order. I thought I would check with the captain. When I told him of the passenger's pet he replied, "No birds." I started to say, "But the papers are in order," when he interrupted me with a cold stare and said, "No buts, no birds on my ship." That night we sailed, minus one parrot.

The other officers are usually cooperative. They will be very helpful, teaching you shipboard routine, customs and even navigation if you show interest. If you are at all interested in radio, you will find the radio operators to be a very friendly group.

Rapport

The crew will keep you on your toes. Eat a few meals every week with them in their mess room. Try to set up a good rapport and you will have fewer problems. The maritime union is very strong and they can make your life on board very uncomfortable unless you can make them realize you are a "regular guy." It is not easy to do this and still maintain a required degree of aloofness, but it can be done.

There are no special rules for attaining this relationship; I guess it is a matter of personality. There are always some malingerers and goldbricks on board. Some situations may require considerable thought and tact. Rely on other officers if trouble arises. Be careful about declaring a man drunk. This has a lot of far reaching implications. Better to say "I believe he has been drinking" and let it go at that. If you are not careful you will

find yourself caught between the crew and the company on a touchy matter such as this. Let the mate bear the responsibility in this situation. I think you will be better off.

Passengers

Passengers are the craziest people —but they keep life for a ship's doctor very interesting.

On my first trip a nice old lady brought a pair of shoes to my office and asked me if I could repair the soles. I told her I was just a doctor to which she answered quickly: "Oh, just a temporary job will do, when we reach port I'll take them to a regular shoemaker."

A passenger once ran in my office and said, "Don't go away, I want you to look at my puppy." Before I could escape she returned with a massive Great Dane that immediately jumped upon me, flattened me to the deck and began licking my face with gusto. My nurse became hysterical with laughter. When I recovered my dignity, I found that "puppy" was suffering from constipation. I gave him what I thought was a reasonable dose of cascara. I learned afterwards that the deck steward responsible for the kennels was cursing me for a week thereafter.

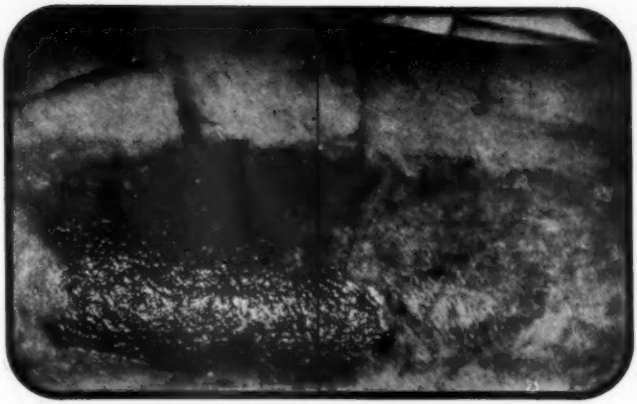
I have had several experiences with schizoid passengers. Incidentally, never go to see a female passenger on a call in her cabin without taking the nurse along. I learned this the hard way. (I'll spare you the details).

Another surgeon told me of a similar mistake. He went to see a woman alone and as he entered the cabin she ran out, half-clothed and screaming. He had a time explaining the situation to the "Old Man" who had his own ideas where surgeons left their Hippocratic Oath when they went to sea. Most people do seem to put off inhibitions on a cruise, but you as a representative of your profession and "on duty" all the time, must hang on to your inhibitions.

In the course of sailing, you will come in contact with many nice and interesting people. People in show business, athletes, diplomats and statesmen, to mention only a few. It is nice to know that in various places in the U. S. and overseas there will be people you can call upon and recall pleasant experiences shared while at sea. Some contacts could prove helpful for your practice in the future. (Save your passenger lists, you may get some patients or referrals later on).

Conduct

Keep well dressed. By that I mean dress according to the occasion. Be in uniform when among passengers. You will command more respect from crew and passengers if you do. Make sure you are on board at least one hour before sailing. Always be on hand to greet officials when arriving in port, no matter the time of day or night.



Skin graft donor site after 2 weeks' treatment with...

petrolatum gauze—still largely granulation tissue | FURACIN gauze—completely epithelialized

OBJECTIVE EVIDENCE OF SUPERIOR WOUND HEALING

was obtained in a quantitative study of 50 donor sites, each dressed half with FURACIN gauze, half with petrolatum gauze. Use of antibacterial FURACIN Soluble Dressing, with its water-soluble base, resulted in more rapid and complete epithelialization. No tissue maceration occurred in FURACIN-treated areas. There was no sensitization.

Jeffords, J. V., and Hagerty, R. F.: Ann. Surg. *145*:169, 1957

FURACIN® . . . brand of nitrofurazone
the broad-range bactericide that is *gentle to tissues*

spread FURACIN Soluble Dressing: FURACIN 0.2% in water-soluble ointment-like base of polyethylene glycols.

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spray FURACIN Solution: FURACIN 0.2% in liquid vehicle of polyethylene glycols 65%, wetting agent 0.3% and water.

EATON LABORATORIES, NORWICH, N.Y.

Nitrofurans—a NEW *class of antimicrobials—neither antibiotics nor sulfonamides*

Be prepared to give advice to other ships via radio. It happened several times to me. The experience of diagnosing and treating someone several hundred miles away by means of radiograms can be most interesting.

Drink sparingly; *never* get tipsy. Emergencies can arise at any time. Keep your cabin door closed and *locked*. Do not hog the pool, gym or dance floor. Do not miss the ship in port—this is the number one sin; also, you may have to catch a plane to the next port at your own expense.

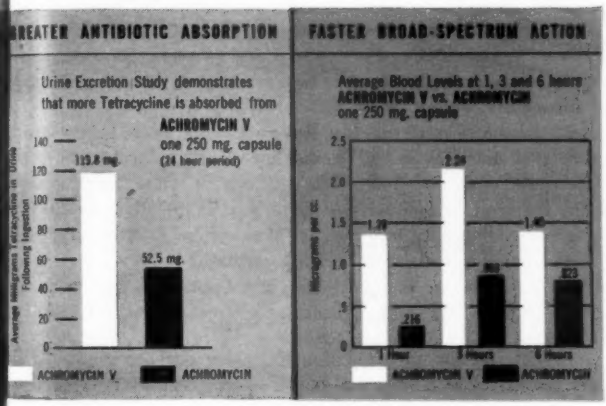
Be nice to your nurse; she works harder than you do and does not have as many privileges. Be cordial to everyone and your future trip is assured, your present one more enjoyable.

If you are planning to bring along a radio, phonograph, electric razor or anything else electrical, remember that the current on almost all ships is D.C. If the appliance is not meant for direct current operation, you will ruin it, as I did in the first 10 minutes aboard ship—(burned out a tube and condenser in my phonograph).

A *converter* is necessary for all electrical equipment using A.C. current only. This may cost you from $10 to $20.

If you can afford it, a portable short wave radio such as RCA, Zenith, or Stromberg Carlson will be handy. Most ships print a daily

"I'm sorry, but I haven't been able to find any reference in the literature concerning a PAIN BETWEEN TWO FLAGS."



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Tetracycline equivalent to tetracycline HCl.. 250 mg.

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newspaper and present the news in capsule form. A radio, however, is nice for listening to current sports, big news as it happens, and music at night.

Hints

Keep your narcotics well locked in the provided safe. If they are lost you will have troubles.

Do not try to beat the customs people. It's not worth the risk. Make sure you declare your foreign cameras or binoculars *before you leave the U. S.* Otherwise you will have to pay duty on them to bring them back into the country. You are allowed one bottle of liquor and $10 worth of merchandise duty free each trip. On anything over this amount you will have to pay duty. The purser will explain the more detailed regulations to you. Incidentally, passengers will sometimes offer to bring in things on their declarations for you. This is illegal for them and for you.

Back for more

To sum up, the advantages and good times far outweigh the disadvantages and headaches.

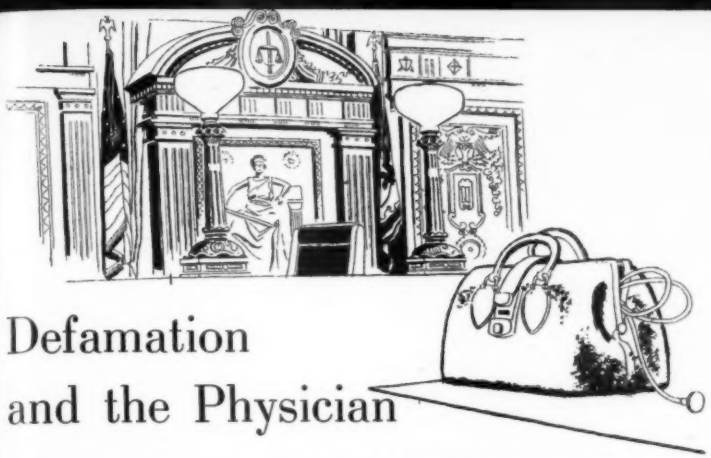
Sure, you will have to endure crazy captains, demanding passengers, a few obnoxious crew members, some nights without sleep and foul weather.

However, the good times and genuinely good medicine you can practice will be more than enough to keep you happy. I cannot think of a nicer or more profitable extended vacation.

The first chance I have I'm going back for six more months, or maybe longer!

Maple Sugar Urine Disease

This new disease, identified by a characteristic "Maple Sugar" odor of the urine of the infants afflicted with it, is caused by an abnormality in the metabolism of leucine, isoleucine, and valine. It appears to be extremely rare. There are indications that the disease might be controlled. As furthur studies of this disease are urgently needed, will physicians who see an infant having a urine odor similar to that of maple sugar please contact Dr. L. Emmett Holt, Jr., Department of Pediatrics, New York University-Bellevue Medical Center, 550 First Avenue, New York 16, N.Y.



Defamation and the Physician

The tongue is sometimes mightier than the pen—and can be equally as damaging. While truth is a complete defense in libel actions, there are specific situations in which false statements are considered privileged.

George A. Friedman, M.D., LL.M.

The doctor, like any other individual, speaks at his peril when making false derogatory statements about other persons.

Libel is *actionable written defamation.*

In order to constitute libel or slander, the statement must be derogatory and it must be published.

Thus, the statement *must be made to at least one person other than the plaintiff* and, except in a limited group of cases to be discussed, it must cause damage or injury to the reputation of the plaintiff.

It may surprise you to learn that libel suits against the American Medical Association have claimed over $30 million in damages since the A.M.A. started its campaign of exposure of quackery, charlatanism and swindling of the public by disreputable "healers," unlicensed doctors and "diploma mills."

What defense is available to the doctor when he is the defendant in such a suit?

Truth, privilege

Truth is always a complete defense to a suit for libel or slander. Further, the most common defense is that of privilege. Though a statement may be false and defamatory, the defendant is not liable for damages when he is privileged to speak

in furtherance of some interest which the law regards to be of sufficient social importance to warrant risking injury to some members of the community.

In the cases against the A.M.A., the only decision against the Association resulted in a one cent judgment for the plaintiff.[2] Publication of magazine articles by the A.M.A. was privileged since the subject matter related to matters of public concern; were published for general information; and the comments and criticism contained therein were reasonable and fair.

Absolute privilege

Under certain circumstances, any oral utterance or written communication may be absolutely privileged (i.e., non-actionable) even if false.

This absolute privilege extends to all judicial, legislative or executive proceedings. This encourages the fullest and frankest testimony, and permits officials wide latitude and discretion in the discharge of their duties without fear of legal recrimination.

A physician who is a witness in a law suit is protected against a libel suit by this absolute privilege in connection with anything he might say on the witness stand, or any affidavit he might have made in connection with the litigation. (Any false sworn statements, however, may subject the physician to criminal prosecution for perjury.)

In Jarman v. Offutt, a physician certified the plaintiff for commitment to a mental asylum without examining her. The physician was held to be protected by the absolute privilege applicable to judicial proceedings.[3]

The defendant psychiatrist pronounced plaintiff, a jail inmate, to be suffering from paresis and caused him to be confined to an insane ward. The court held that the defendant acted in the official discharge of his duties and was not liable for damages in a civil action because of a mistake of fact made by him in the exercise of his judgment or discretion.[4]

A masseur filed a petition with a city council to be granted a license despite failure of the health department examination.

Defendant physician, head of the health department, in reply to a query by the city council, produced data from the departmental file showing that the plaintiff had committed certain violations of the Medical Practice Act. He stated that plaintiff advertised a cure for influenza through the press, and was charged with practicing medicine without a license. This latter charge was not pressed since the complaining witness failed to appear.

The court held that the physician was acting within the legitimate exercise of his duties and that he was absolutely privileged.[5]

Statements made by a physician to his spouse are absolutely privileged. Statements to which a person has given his consent are also absolutely

invitation to asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes . . . Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

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privileged as for example a request for a recommendation.[6]

Qualified privilege

There are other situations which confer upon the doctor a privilege less than the absolute. Here the condition imposed is that the publication be in a reasonable manner and for the proper purpose. That the facts stated are false will not of itself defeat the privilege unless the court infers from the falsity, malice and unreasonable manner.

A physician may speak to protect the interests of his patient. Thus, when the patient's mother asked the defendant physician which pharmacy he would recommend to fill his prescription, he replied: "Do not carry the prescription to Cash Drug Store; their drugs are an inferior grade and their druggist inefficient." Althou other close relatives overheard t statement, the occasion was he privileged.[7]

In 1947, in California, a physician mistakenly told the plaintiff she was afflicted with a venereal disease. The statement was made within hearing of a bystander, not known to be present. The privilege was upheld. Since the patient refused to return to the doctor's office, and it was incumbent upon the doctor to inform his patient of the supposed facts, it became necessary to do so in her own surroundings.[8]

Similarly, a specialist conveyed an erroneous diagnosis of syphilis to the plaintiff's family physician. There was a duty to report the diagnosis; and the circumstances were held privileged.[9]

A communication between an employer and his employee is protected by this privilege. The physician examined a patient on request of patient's attorney. A letter from the doctor to the attorney advising that the patient's mental state was abnormal was held to be a privileged communication.[10]

A physician, like anyone else, may speak to protect his reputation. In Shankman v. O'Malley, when the plaintiff physician claimed that a baseball club ran out on his bill, the response was made by the manager of the club that the doctor thought he was operating on the bankroll of the ballplayer. This was held to be privileged to protect the

reputation of the club.[11]

Qualified privilege has also been extended to communication among members of professional societies, so long as the publication is not made to persons outside of the organization.

Qualified privilege extends to the publication of matters which affect the interest of the general public.

Brinkley v. Fishbein was an action for libel based on an article published in a medical journal called *Hygeia*. The article labeled plaintiff as a charlatan and described his activities. The plaintiff performed transplantations of goat glands into males to produce sexual rejuvenation. He injected mercurials into the male prostate gland. His advertisements in newspapers, pamphlets and on the radio employed in the furtherance of his quackery were delineated. The revocation of his medical and radio licenses was described. Further, the article described prescriptions by letter for persons who had described their symptoms by mail.

Public interest

The court found that these facts supported a reasonable and honest opinion that the plaintiff was a charlatan and that the comments were privileged since they were made in the public interest.[12]

However, as to how far this privilege extends, there is a conflict of rulings. In Rood v. Dutcher, the court held that a newspaper which labeled an E.N.T. physician a quack and imposter who botched his operations, was liable for damages to the doctor.[13] The facts stated were false. In the majority of jurisdictions, although the facts stated and the conclusions and comments based thereon are both false, the statements may be privileged if the court finds that the falsity evidences neither malice or evil intent. In the minority of jurisdictions, the privilege is completely destroyed merely by a false statement of facts. In these jurisdictions, a true factual statement with false derogatory comments may still be within the privilege if the other conditions of the privilege are fulfilled.

There is far more latitude in the area where opinion only is expressed on matters of public concern.

In 1943, Dr. Berg, a psychiatrist, sued for libel on the basis of an article entitled "Dusting Off Dr. Berg." The article was a criticism of two papers written by plaintiff on the effect of radio programs on an audience with special reference to adolescents and women. The alleged libelous article criticized Dr. Berg's papers as sensational, without facts, and unscientific as an approach for a scientist.

It commented further, "Radio objects to the reckless application he has made of his findings; . . . the mounting hysteria of his surmises." The court held that only the writings and not plaintiff were criticized, and were privileged as honest criticism.

Anything that is submitted to the public for its approval comes within this area of free discussion on matters of public concern. A proprietary medicine was called, among other things, "common old whiskey thinly disguised." The newspaper article was held to be within the privilege.[35] But in 1940, in Arkansas, the founder of a private hospital was found guilty of criminal libel. First, the hospital was held to be not an organized charity conducted in the public interest. Then he published a letter in a newspaper charging the prosecuting witnesses with attempts to undermine the hospital. They were accused of repeating falsehoods about the doctors in the hospital; and of endeavoring to deprive the hospital of patients. This case was just on the wrong side of the often hazy line which divides public from private concern.[36]

Retraction

Truth and absolute privilege are complete defenses and when successfully interposed, plaintiff recovers nothing.

Suppose, however, a physician finds he has made a mistake. He cannot plead truth. He had no absolute privilege to speak. He should then retract the defamatory statement in the same form and in the same forum and with as much publicity as he originally made it. This retraction may lessen damages to a great extent. Or it may evidence the good intentions and worthy motives of the speaker so that a jury could find that the conditional privilege on which defendant was relying was not abused.

Defamation

Generally, there can be no recovery in a law suit unless the plaintiff proves to what extent he has been damaged. Where certain defamatory statements are made, however, there is recovery without proof of damage.

Such cases are known as defamation per se. In these instances, the existence of damages is conclusively presumed from the publication of the libel or slander itself.

Under this category would be defamation affecting the plaintiff in his profession. Defamatory words which

impute to a physician a want of professional skill or knowledge, or general unfitness or incompetency, are defamatory per se.

So, to say of a doctor that "he is a butcher and the speaker would not have him for a dog" is defamation per se.[17] It is the same to charge a doctor with killing a patient.[18]

A newspaper article stated that a duly licensed physician came to the community "apparently to complete a medical and surgical apprenticeship."[19] Another newspaper article referred to a group of doctors as "jackasses in guise of doctors . . . brutes to care for us in sickness, and ghouls to mutilate us when dead."[20] These and other references to doctors as humbug, quack, blockhead, quicksilver, empiric, mountebank, or to say of him that he is no scholar or his diploma is worthless[21], or that he was drunk when needed and couldn't attend,[22] were all held to be defamatory per se since they lessened the public confidence in the defendants as medical men.

To charge a doctor in a particular case, however, with an incomplete examination,[23] or mistake, negligence or unskillful treatment, is not defamatory per se and a libel case will fail without proof of special damages. The courts consider that this differs from a charge of gross misconduct which implies the unfitness of a doctor in his profession. All human beings make mistakes.

A newspaper article told of a physician who diagnosed a case as "alcoholic paralysis." The patient died shortly thereafter of a broken neck. The article was not libelous.[24]

Certain acts or omissions, however, may evidence such ignorance and want of skill that to accuse a doctor of their omission may injure his general character and reputation. In Summer v. Utley, it was said of a doctor that the patient died "through his mismanagement. He left the afterbirth."[25] This differed from a mere charge of negligence or mistake.

To call a doctor an adulterer is not actionable without proof of damage since it does not injure his professional reputation. He might still be a good physician.[26]

Other remarks which are defamatory per se are those charging a doctor, or any other person, with commission of a crime, such as abortion[27] or perjury[28] or to call him a communist.[29]

Class suits

A doctor can be defamed even if he is not named so long as a reasonable person believes that the words refer to the plaintiff. A general statement that all doctors are quacks, or all lawyers are shysters, would involve no defamation since the group is so large as to defy identification of any member. But if only one doctor is present when the remark is made, the court may well find that personal reference is intended, and that plaintiff was within the class defamed.

If the group is a small one, all

persons included within it may be defamed. Bornman v. Star Co. was a case discussed by a newspaper in which plaintiff and eleven other doctors took a dead man from a charity hospital and hung him in effigy of the hospital superintendent because of their impatience with the house rules which he imposed. Among other things, the newspapers called the doctors "jackasses," but named no one. The court found that there was direction to plaintiff.[20]

Dr. Arnott was a member in good standing in a Canadian community. He introduced the "Koch" method of treatment for cancer, and became well known as a "Koch" disciple. A Medical Quarterly wrote: "We know the Koch treatment is quackery." Though the plaintiff was refused recovery because the article was privileged, the court assumed that reference was made to the plaintiff despite the fact that he was unnamed.[21]

Publication

A sine qua non of defamation is publication to a third person. The question often arises: Who is a third person? A spouse is not a third person. What about a secretary, stenographer or nurse? Cases are divided on this question. Most hold that dictation to a secretary is not publication. A few, however, hold otherwise.[22]

It is probably safe to rely on the following: that there is no publication in cases where discussion is necessary to the course of treatment as with a nurse. Likewise is it so where the plaintiff expects a physician to use a secretary in connection with notes on his case or letters that are to be written to him.[23,24]

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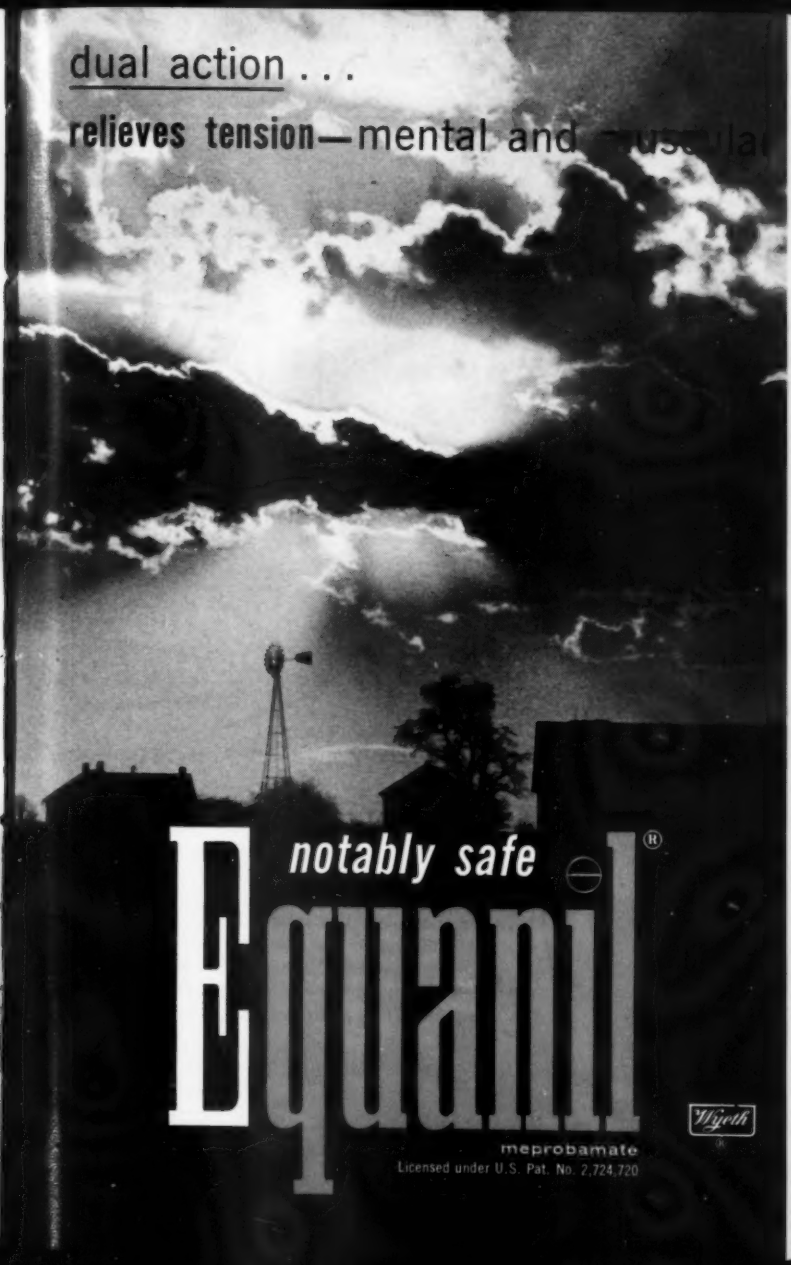
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1. Best & Taylor, The Physiological Basis of Medical Practice, 6th Ed.

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240 mg.

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Lloyd *BROTHERS INC., CINCINNATI, OHIO*

Strictly On the Record

The selection of musical recordings and playback equipment can become a jungle of indecision for the casual wanderer in the world of recorded music. Yet, there are trails which afford you a safe and pleasant journey through this modern wonderland of music. With a few facts, some common sense and a vast amount of discrimination, the author shows you the way to a deep and lasting enjoyment in your recreational time.

E. M. Fowler

Amateur musicians, residents included, approach their hobby in a number of ways. Some pound the piano, some strum the mandolin, others tootle the sax or trumpet, but most just listen. Some of the world's most discerning music lovers don't know a hemidemisemiquaver from a harpsichord.

But they know what they like.

And if they have any sensitivity, what they like generally turns out to be "good music."

To be a good listener you need a maximum of zeal and a minimum of equipment. First, you must be an explorer. The field of recorded music covers large areas—hard to penetrate jungles as well as easily traversed plains. You must be eager and believe, just a little, in what the magic of music can do to transport you.

You must move slowly along the way, ready for changes and varied experiences; you must make many stops and a few side trips. And you're almost certain to get lost and puzzled occasionally since not all recorded music is equally good; there are plenty of pitfalls, some of which we will try to explain.

Equipment

Secondly, you need good equipment. It need not be expensive. By this we mean you don't have to feel you must rush ahead and buy the latest in hi-fi equipment. There are many types of good phonographs on the market. Since you will probably want to combine listening to records with "live" music, your best buy is a standard make of a radio-phonograph with at least an eight-inch speaker.

To get the best results from today's fine recordings you must be able to pick up both the high and low tones—and you can't do this on a Mickey Mouse wind-up toy.

If you are mechanically-minded you may be able to build your own set from parts more cheaply than you can buy a ready-built model. However, if your mechanical aptitude is limited to medicine and surgery, you can find a good enough combination radio - phonograph for as little as $75. Naturally, the more expensive the set, the more gadgets and the higher the upkeep; but not necessarily a better quality of reproduction.

A word of caution. Most of the good makes such as RCA, Philco, Zenith, etc., are sold through many outlets ranging from department stores to discount houses.

They can be abused before you even get them home. Hence, two apparently identical models may exhibit totally different performance, depending on the number and gentleness of hands through which they have passed.

A friend recently purchased an expensive Magnavox through a large radio and record house. He paid cash. The machine resounded with static and the turntable was defective. A repairman from the store came to fix it, took it away and returned it in worse shape than before. In righteous wrath our friend demanded his money returned, whereupon the president of the store haughtily refused to do anything beyond substituting another model. Our friend dispatched an irate letter to the president of the Magnavox Company. That resulted in action: the set was removed and his money was returned. Then our friend went to a large department store where he had a charge account, explained the situation, was sent another Magnavox which has worked beautifully with no repairs for six years. The moral of this: charge expensive items. This practice gives you a month to test the machine before you pay. Moreover, charge customers usually get considerate treatment and good service.

Working order

Once you have bought a set do it the justice of keeping it in good order. Don't let other people fuss with it until you have explained how it operates.

Like patients a phonograph will usually respond favorably to kind treatment and occasional medicine.

For example, the first malfunction will probably be due to a dead tube. If so, take the tubes to your local radio supply shop and have them tested. For a few dollars you can replace the dead one, without the expense of hiring a serviceman.

However, if the set requires more expert attention put it in the hands of a good serviceman. The store where you bought the set may offer repair service or will send you to a good man who will have correct parts.

For some reason many people will pay lots of money for a set without even bothering to ask about the needle in the pick-up. Since the needle transmits the sound to the loudspeaker it is a most important item in your set. It is a good idea to find out just how good the needle is, and what kind to use in the future. When you do replace the needle make sure it is put in at the correct angle in the pickup arm (most needles are placed at an angle to the playing surface) because any deviation can spoil a fine record.

Tape recorders

If you've ever had the sad experience of listening to something especially good on the radio and then not been able to find it on records, you are a good bet for a tape recorder. These devices are similar to a dictaphone or ediphone in that sound is transmitted through a microphone. However, instead of grooving a plastic record, the sound magnetically sensitizes the surface of a tape (which is covered with microscopic bits of metal). The tape recording can be kept and replayed indefinitely without impairing its quality—unlike the disc-type records. Or it can be "wiped" clean (electronically erased) and used over and over again, re-recording on and on.

Since the first recorder went on the market about ten years ago, they have been much improved. Almost every good radio maker puts out at least one model. Some like Web-

At Your Request . . .

In a recent survey of residents conducted by your journal, music headed the list of recreational interests. Nearly three quarters of the survey group, representing five percent of all residents, reported that their favorite spare time enjoyment was playing or listening to music.

Many respondents asked for information on building a good record collection and some hints on evaluating recording quality—both the records and the record player.

So here, both for the beginner and the advanced recordiophile, is the first of two articles designed to give you a brief guide in your purchase of records and equipment so that you'll get the fullest possible satisfaction from your off hours listening.

'Thorazine' relieved this patient's severe anxiety and helped her to gain insight.

"No X-ray sees my cancer."
"...nothing stops my pain."

'THORAZINE' CASE REPORT

patient: 60-year-old female. After death of relative from cancer, patient developed severe epigastric pain, was convinced pain was due to hidden malignancy which defied the X-ray. Her pain was unresponsive to antispasmodics. Her severe cancerphobia was untouched by sedatives and she refused psychotherapy.

response: Complete relief from pain was obtained after two weeks of 'Thorazine' therapy.

Patient then stated she "knew all the time it wasn't cancer." 'Thorazine' was instrumental in providing both relief and insight when "many drugs and attempts at reassurance had failed."

This case report is from the files of the patient's physician; photo professionally posed.

THORAZINE* one of the fundamental drugs in medicine

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

ster, Chicago, Ampro, etc., have them in all price ranges.

You can buy a good one for about $125-$180; extra blank tapes with about two hours playing time each cost $2. Tapes can be indexed, stored away on reels and kept permanently.

Features

Some machines are "portable." Not much larger than a typewriter and weighing about 25 pounds, these are easily put out of the way when not in use. Anytime you wish to record something you merely plug in the recorder, throw the switch and let it turn to your heart's content.

When you really want to do a good job—such as recording an entire opera or symphony concert played over the radio—run a couple of pilot tapes first until you get the right pitch and volume. (You won't get a second chance!) In other words, analyze your subject matter just the way you'd figure speed and light requirements when using your camera.

A number of companies put out pre-recorded tapes. Though such compositions are found in nowhere near the variety and number as 33-1/3 long-playing records, the supply is growing.

Before you buy a tape recorder check such features as the range in cycles per second (determines how deep a base and how high a treble you'll get of good tonal fidelity). There's the item called *frequency response*. What about wow and flutter? (Distortions of sound on sustained notes spoil reproduction.) How many speakers? What kind of tape drive mechanism, controls, amplification and tuning, sound level indicator, measuring indicator? It sounds technical but it isn't really involved. Ask for some help, if you wish—but remember, excellent recorders are available for under $200!

Also, your first tape recorder can find a useful home when you're ready to step up the ladder in quality. Many physicians today are placing taped music in their waiting rooms to relax their patients. (If only some music could be sent along with the bill for services!)

Listening

Now that you have taken every sensible step toward listening pleas-

use, let's discuss a record collection. Here is where we take a big, big breath. We wish to announce we are not professional music reviewers, we are not in the pay of any record company, and we're not out to praise any particular school, type or period of musical composition and reject all others. Almost any composer whose works have been recorded has some merit—from Gabrieli to Gershwin. No two people like identically the same group of musical pieces. And there is no approved way to broaden your musical tastes other than to listen, listen and listen some more.

When we first caught the music bug back in the primitive (or 78 rpm) days we thought the Triumphal March from "Aïda" was the greatest. We still think it's good but we also like many other pieces as well and better. So you can expect and should be pleased that your tastes will change and broaden as you listen.

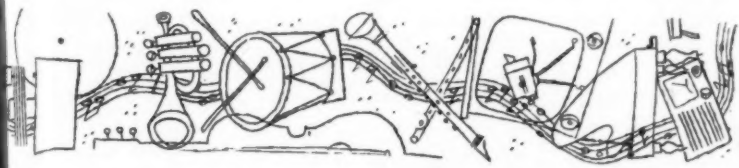
Remember, you are starting a collection for your own enjoyment, not to prove your musical erudition, so don't let anyone tell you what you should or should not like. Nine times out of ten, after you've started to collect records you like you will have as fine a group as anyone who prefers so-called expert, critical advice.

Starting collection

As a starter, jot down the names of compositions you like wherever you come across them—on radio, via TV orchestras, even in the movies. Buy a few of the ones you like most. Once you grow attached to a record by one composer you will probably be curious about some of his other works, you may want to know something about his life and how critics rate him. At this point—when your curiosity is aroused, buy a book on music—(or get one at the nearest public library). You'll greatly extend your enjoyment by a knowledge of the background of a composition.

Before you know it you will experience an illness peculiar to all record bugs: You will want more platters than you have dollars. In a way this is a favorable condition because it forces you to show discrimination.

If you're a beginner, stick to the more familiar classics until you are well grounded. There are two good



reasons for this. First, the popular classics, because they are familiar, are easy on the ears. Second, because of their popularity you have more recordings to choose from. Just to give you an idea, here are the number of recordings available at the present time for a few of the better-known classics:

Composition	*Number of recordings*
Beethoven Symphony No. 5	22
Beethoven Moonlight Sonata	16
Brahms Symphony No. 1	20
Rimsky-Korsakov Scheherazade	19
Strauss (Johann) Waltzes	33
Tchaikowsky Piano Concerto No. 1	20

Best orchestra

You may well ask, "What is the *best* orchestra or recording artist?" This again is entirely — well not entirely — a matter of individual taste.

Generally speaking, for sheer drive and vitality you simply cannot find a superior to Arturo Toscanini. Although some critics question his interpretative methods, each of his recordings is an experience in itself.

Bruno Walter's approach to his favorite composers such as Brahms and Mahler is more rounded and mellow; he probably comes as close as anyone living today to the true flavor of the German and Austrian romantic composers.

Ernest Ansermet and Charles Munch and Pierre Monteux are perfection in evoking the delicate nuances of the French composers.

A Russian himself, the late Serge Koussevitzky and the Boston Symphony turned out some stirring performances of Russian music, both old and modern.

If, like most amateurs, you are attracted by the actual sound effects of the recording then the Philadelphia Orchestra and its conductor, Eugene Ormandy, will surely please.

Cost

You can start an excellent collection of orchestral pieces for under $100. By setting aside one dollar a week, you'll accumulate gradually, enjoy each one fully.

The following list of *suggested* recordings is not necessarily basic nor the very best examples of a particular composer's works but we like them and we think you will too. These are all 33-1/3—other speeds no longer offer as wide a range of choice.

1. Bach *Suites No. 1 and 2.* Pablo Casals and the Prades Festival Orchestra. Columbia 3ML-4348.

2. *Beethoven Symphony No. 5 and 8.* Arturo Toscanini and the NBC Symphony. Victor LM-1757.

3. Beethoven *Violin Concerto in D.* Zino Francescatti and the Phila-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1. Blanchard, K., and Ford, R. A.: Journal Lancet 74:443, 1954.
2. Blanchard, K., and Ford, R. A.: Rocky Mt. M. J. 52:278, 1955. 3. Case, L. L., and Frederik, W. S.: Am. Pract. & Dig. Treat. 2:844, 1951.
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Glycerol guaiacolate . . 100 mg.
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Prophenpyridamine maleate . . . . . 7.5 mg.
Codeine phosphate . . . 10 mg.
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Robitussin with Antihistamine and Codeine

delphia Orchestra with Eugene Ormandy. Columbia 3ML-4371.

4. Brahms symphonies (all four) and *Academic Festival Overture*, plus *Variations on a Theme* by Haydn. Bruno Walter and the NY Philharmonic Symphony. (This is a fine record set and is worth the high price; it is one of the most satisfying collections in the whole repertory of recorded music.) Columbia SL-200.

5. Debussy *Les Images pour L'Orchestre.* Ernest Ansermet and L'Orchestra Suisse Romande. London LI-44.

6. Dvorak *Symphony No. 5* from the "New World." Toscanini and the NBC Symphony. Victor LM-1778.

7. Gershwin *Porgy and Bess; Symphonic Picture,* Andre Kostelanetz and the NY Philharmonic Symphony. Columbia 4ML-4904.

8. Handel *Concerto No. 1 and 2 for Orchestra and Organ.* Ansermet and L'Orchestra Suisse Romande. London LL-695.

9. Rimsky-Korsakov *Scheherazade.* Ormandy and the Philadelphia Orchestra. Columbia 5ML-4888.

10. Rimsky-Korsakov *Capriccio Espagnol.* Ormandy and the Philadelphia Orchestra. Columbia 3ML-4856.

11. Strauss (Johann) *Waltzes.* Fritz Reiner and the Pittsburgh Symphony. Columbia 3ML-4116.

12. Strauss (Richard) *Don Juan* and *Death and Transfiguration.*

Bruno Walter and the New York Philharmonic Symphony. Columbia 3ML-4650.

13. Stravinsky *Firebird Suite* and *Sacre du Printemps.* NY Philharmonic Symphony Orchestra (conducted by the composer). Columbia 4ML-4882.

14. Tchaikowsky *Symphony No. 4.* Koussevitzky and the Boston Symphony. Victor LM-1008.

15. Tchaikowsky *Symphony No. 5.* Koussevitzky and the Boston Symphony. Victor LM-1047.

16. Wagner *Overtures to Die Meistersinger, Tannheuser,* and *The Flying Dutchman.* Szell and the NY Philharmonic Symphony. Columbia 3ML-4918.

17. Wagner *Die Gotterdammerung* (excerpts) and *Siegfried Idyll.* Toscanini (Helen Traubel) and the NBC Symphony. Victor LCT-1116.

Those are some of the really fine

recordings of symphonic compositions. Imagine yourself now, alone in your room; lean back in your chair, put your feet up and listen to your records. In a few seconds, you are completely relaxed, transported into a melodic space of beauty in sound.

Clear, high quality musical reproduction is one of the really wonderful marvels of our civilization. And others who share your interest will increase your listening pleasure as they join you in a session of listening to the masters in music.

With even a few fine symphonies in your record library, you'll enjoy many hours of pleasant listening. One warning. It's entirely possible that you'll consider some of these pieces a bit longhair for your taste. That's why we strongly urge you to listen first, then buy *only if you're pleased with what you hear.*

Other fields

So much for symphonies. Other, more comprehensive fields of music are found in the operatic, ballet, popular and jazz instrumental, Broadway musicals, and vocals of the semi-classical, popular and jazz tradition.

But enough for now. It's better to take a little bit at a time in any field. Music is no exception. With the rhythms of Calypso added to the scene, new ideas must be digested along with the old. In fact, if we continued to the logical end, we would move into the era of Presleyites and rock 'n' roll. *And that's the livin' end!*

Meanwhile, good listening!

The Social Worker Is On Your Team

The modern hospital prides itself on the variety of services directed toward total medical care of the patient. One of these services is provided by the hospital social worker. In assisting the patient to a solution of social and economic difficulties, the professional social worker aids the physician in removing hidden barriers which often thwart his medical program.

Jeanette R. Oppenheimer

Social service as part of medical treatment, though formally introduced in 1905, is not a totally new concept in the total care of patients. However, the social worker, now invested with this responsibility, is a phenomenon of the 20th Century. Dr. George Baehr, in a recent paper, stated that the "family doctor was the social worker of the 19th Century."

Actually, the rapid changes which have occurred in the practice of 20th Century medicine with all its advances and new tools for diagnosis and treatment, have left the average physician little time to treat his patients' social problems, the true "family doctor" has become rare, being replaced by the specialist.

This change has led to the rise of the non-physician who has been trained as a specialist in social work —the professional social worker.

Pattern

In 1905, at Baltimore, Boston and New York teaching hospitals, recognition was given to the importance of the relationship between illness and social factors, and efforts were initiated to give this factor special consideration in the treatment of patients. Different methods for accomplishing this were developed in these three communities. But Dr. Richard Cabot at the Massachusetts

General Hospital, securing the services of an individual experienced in the field of social work and employed by the hospital, set the pattern as we now know it for the practice of social work in hospitals.

Gradually, social workers acquired increased understanding of the background of training needed in preparation for their profession. As the profession developed an expanding core of knowledge, techniques and skill, there developed the graduate schools for training for social work. As a result, the typical present-day social worker employed in a hospital has completed four years of college plus two years of study at a graduate school of social work from which he or she holds a Master's degree. In addition, today's social worker has had extensive experience in supervised case work practice, often in a hospital, and special training in problems peculiar to the medical setting.

Special knowledge

While there may be variations among individual institutions, the basic function of the social worker in the hospital is related first to the care of the patient. Special knowledge combined with skill as a case worker enables the social worker to relate the social and emotional factors in the background of the individual patient to his medical problems. The goal is to enhance the physician's understanding and treatment plan, and to enable the patient to make maximum use of the medical care provided him.

Obviously, the ability to remain objective with the hostile or uncooperative patient is important. In fact this, together with an understanding of the basis for his behavior, may often be the foundation for the patient's successful participation in medical treatment. Finally, knowledge and ingenuity in the use of social resources often enables the social worker to help the patient mobilize himself into using what is available to him in the community.

It is not simply the knowledge of what social resources exist in the community; the skill in helping individuals to make effective use of these resources is one of the important contributions of social case work. Conversely, when resources are lacking, the social worker often will help find means by which resources may be developed.

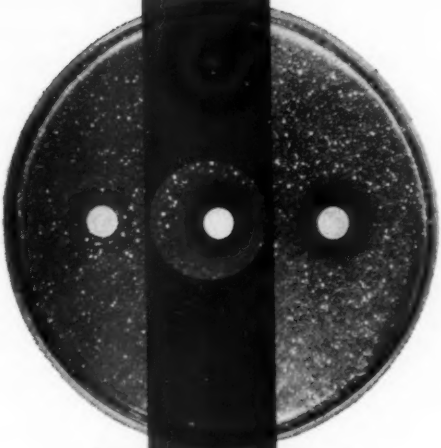
The amount of time required with each patient varies and is not necessarily indicative of the degree of professional skill involved.

Case of worry

An example of a case requiring only a brief contact was that of Mrs. A., a 32-year-old married woman. She was referred to the social worker by a head nurse who noted that the patient appeared depressed and worried about her family. The patient, admitted to the hospital the previous day with a post-partum infection, was the mother of six chil-

dren ranging in age from six years down to the newborn infant of one month. A check revealed that the patient, because of her hospitalization, had been forced to make temporary plans for her family which necessitated her husband remaining home from work. Her husband was a physicist, earning a salary adequate for the family's needs but insufficient to provide full-time housekeeping help.

In a conference with Mrs. A.'s gynecologist, the social worker was advised that the patient would require a couple of week's hospitalization followed by a prolonged period of convalescence at home. Discussion with Mrs. A., a proud, independent woman, was focused on helping her recognize the validity of a request for assistance from an agency for homemaker service. She was encouraged to discuss the plan with her husband. Once the couple resolved their reluctance to ask for help, the social worker presented their special problem to the family agency, which, though experiencing budgetary limitations, recognized the importance of the medical-social problem and its impact on this family of eight persons. After arrangements were concluded for a homemaker, the family making a limited financial contribution, Mrs. A. became cheerful and relaxed and was able to remain hospitalized and con-



Result[illegible] culture

of E. coli and Candida albi[illegible] Phosphate (left) eliminates the bacteria, but not the mo[illegible]ns). Panmycin Phosphate and Nystatin combined (center) e[illegible] bot[illegible]e bacteria and monilia (clear ring). Nystatin (right) elimin[illegible], but not the bacteria (haze).

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valesce sufficiently long enough to anticipate complete recovery.

Referred for care

In marked contrast to Mrs. A. was Miss B., a 40-year-old patient who was referred by her private physician to the social worker for nursing home or other form of chronic care. Miss B. had been hospitalized for about two weeks because of urinary retention related to spinal cord atrophy. Although primarily a neurological problem, she was at the time under the care of a urologist. He informed the social worker that Miss B. was rapidly becoming a paraplegic. She had been in another private hospital three months previously and as an ex-W.A.C. had transferred to a Veterans' Hospital from which she had signed out against advice—and consequently could not be re-admitted to any Veterans' facility for 90 days.

The doctor stated that she could not return home because she roomed out and had no family who could care for her; if she could be referred for rehabilitation, it might be possible for her to function fairly adequately.

From the social worker at the first hospital it was learned that Miss B. had been a difficult patient; she had been unable to accept the

chronicity of her illness and adapt her life to this fact. She had conceived an elaborate plan for keeping her father and brother from the knowledge that she was ill, even resorting to the device of forwarding mail out to the Pacific Coast to be re-mailed to them on the pretext that she was there on business.

She had been showered by attention from friends and had manipulated them to an amazing degree to do her bidding. Her problem was further complicated by the fact that she had become addicted to narcotics during her hospitalization.

Caution

With this information as a background, the social worker's approach was cautious; for several days the case work interviews were directed solely toward establishing a friendly relationship with Miss B. Eventually, Miss B. was able to ask that the worker communicate with her employer. (Miss B., prior to her illness had held a responsible executive position in a large department store and, although ill for six months, was still receiving full pay.)

Miss B. was somewhat anxious about remaining in the hospital when she recognized very little could be done for her.

This enabled the worker to begin to discuss her need for rehabilitation and, although Miss B. could not accept the probability of a wheelchair existence, she could begin to admit her need for prolonged treatment "to restore function in her legs."

Before arrangements could be completed to transfer her to a municipal hospital for evaluation of her potentiality for rehabilitation, the patient developed a new set of symptoms which, in her physician's opinion, were suggestive of progression of her disease and a poor prognosis for life.

Thus, the rehabilitation plan had to be discarded and the patient helped to accept transfer to a Veterans Administration hospital. By this time the patient had confidence in the social worker and could discuss her feelings about her illness and previous hospital experience.

Led to recognize that the only realistic plan for her was to reapply for V.A. admission and having come to this decision, once again Miss B. began to manipulate her friends and contacts for a prompt transfer to a V.A. hospital. Though she was unable to by-pass the 90-day regulation, the interval was nearly up.

Miss B. had become a severe nursing problem; her care was increasingly time-consuming and she required heavier dosages of narcotics for pain. She became quite demanding. Both the social worker and the physician frequently had to interpret her special needs to the nursing staff.

Unfortunately, Miss B. developed some paranoid-like ideas in relation to the nurses and her need for medication. Her depression mounted

and several times she demanded that the social worker and a distant relative who maintained a close relationship with her, arrange for her transfer to a nursing home. Since no nursing home was available to meet her special needs, this request was handled by "delaying tactics" until she was once again satisfied to await transfer.

Adjustment

In an effort to help the patient face the physical limitations and prolonged nature of her illness, the worker encouraged her in her development of intellectual interests in contrast to her former preoccupation with active sports, and also to reveal her illness to her father and brother. Since she was still contributing to the support of the former, it was important that she begin to conserve her dwindling financial resources. And though she remained adamant, information concerning her condition was eventually released by her employer when her family became suspicious of her indefinite absence from the city.

As the time came for her transfer, the social worker, to help in her adjustment to the new hospital, immediately referred her to the social service department of the V.A. hospital.

Subsequent reports from her physician indicate that she now has settled into the long process of rehabilitation and is beginning to learn to live with her illness.

Private patient

Thus it may be seen that the social worker's services can be appropriately utilized in the care of the private patient as well as for clinic or service patient.

Frequently, the social worker can offer the individual resident or attending physician information concerning the patient and of value in treatment of the patient. This is possible even without the social worker having any direct contact with the patient.

Activities

Related to the social worker's primary role in the care of the patient are other areas in which she is frequently involved, including the teaching of medical students, interns, residents, and student nurses. Whether on rounds, in conferences, in the classroom, participation in special research projects, or in community activities related to health and welfare, the social worker is a member of the hospital team and can contribute her knowledge and experience to the welfare of the patients.

The extent to which social workers can assist in the care of the patient depends in large part on the degree to which the house staff and attending staff accept the value of the social worker's contribution.

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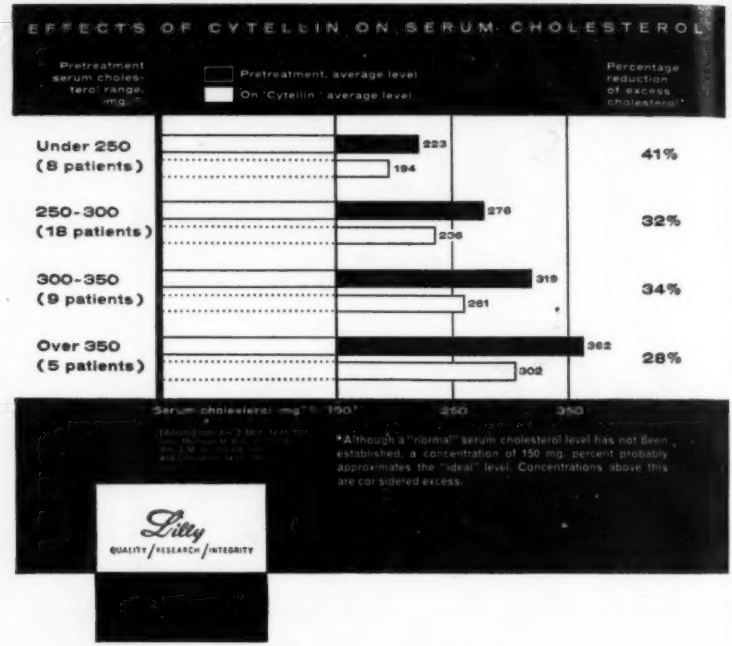

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between social and emotional factors in disease, it follows that the social worker will be found with increasing frequency not only in governmental hospitals and in university and other teaching centers, but also in the smaller community, nonteaching hospitals where patients expect and are entitled to the same high quality of medical care.

"The gloves won't be necessary, doctors—I'm clean!"

RESIDENT HONEYMOON

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Licensure for Foreign Graduates

in California, Colorado, Connecticut

CALIFORNIA

The California Board does not approve any foreign medical schools but considers each application as it is filed.

An applicant whose application is based on a diploma issued to him by a foreign medical school, except a Canadian school, must furnish documentary evidence, satisfactory to the California Board, to support the following:

- He has completed, *in a medical school or schools*, a course of professional instruction equivalent to that required in California medical schools.
- He has had issued to him by such medical school, a medical diploma, as evidence of the completion of the course of medical instruction.

Graduates of medical schools located in foreign countries will please bear in mind that the word *diploma* as used here refers to a document issued by a medical school after completion of the medical course, and is termed in most countries as a *doctor of medicine diploma*. Graduates of foreign medical schools often refer to their license to practice medicine as a "*diploma*." The latter document is known in the United States as a *medical license*, not a diploma.

- He has been admitted or licensed

Each state of the United States has established its own regulations for licensing physicians to practice medicine within its boundaries. For the U. S. medical school graduate, rules are much the same from state to state. But for the graduate of a foreign medical school, there are important differences.

to practice medicine and surgery in the country where he completed the courses of professional instruction required.

● The country in which he has been licensed to practice medicine and surgery will admit to practice citizens of the United States upon proof of prior admission to practice medicine and surgery in some state of the United States, or upon proof of matters similar to the requirements in this section for graduates of foreign medical schools.

Translations

All credentials from foreign institutions must be translated *into English* by the consul and over the seal and signature of the consul of the country where such documents may have been issued. Consul must certify that the institution is recognized or approved by the authorities in the country in which it is located.

English translations must be attached to each document in a foreign language.

California training

Applicants under this section must serve at least *two years* in a service satisfactory to the California Board in a hospital or hospitals located in the United States and approved by the Board for the training of interns. *One year of this training must be in a hospital in California.*

Before a certificate may be issued, the applicant must also pass a writ-

A License to Practice

The philosophy of state licensure is to insure the American public the highest possible level of professional competence in medical care. For foreign-born graduates of foreign medical schools, and for American-born graduates of foreign medical schools, the licensure requirements of most states represent a serious obstacle.

In some states it is impossible for the foreign-trained physician to obtain a license. Proud of his own training, the foreign-trained physician is apt to resent this and wrongly conclude that these states prohibit licensure of foreign-trained physicians solely because they are *foreign-born*. (This is not true. American-born physicians trained abroad meet exactly the same exclusion in these states.) However, it is true that certain states make this exclusion because they do not believe they have adequate facilities or criteria at present for examining each foreign-trained physician who wishes to apply for licensure.

For some time there has been a growing effort to establish a uniform medical practice act acceptable to all states. But in the interim, the foreign-trained resident must check individual requirements established by the state in which he desires to practice in order to determine his eligibility for licensure.

It is to make this task a little easier that RESIDENT PHYSICIAN presents this series of articles on state licensure requirements.

ten examination prior to commencing an internship in a hospital in California, and must also pass an oral and clinical examination upon satisfactory completion.

The Board may disapprove any foreign medical school or deny any application if, in the opinion of the Board, the instruction received by the applicant or the courses completed were not equivalent to that required in this article for a physician and surgeon applicant.

U.S. citizens

An applicant who at the time of his application and at the time he commenced his resident course of professional instruction was a citizen of the United States and whose application is based on a diploma issued to him by a foreign medical school, except a Canadian school, shall furnish documentary evidence, satisfactory to the Board, of the following:

- He has completed *in a medical school or schools* a course of professional instruction equivalent to that required in this state for a physician and surgeon applicant.
- He has had issued to him by such medical school, a medical diploma, as evidence of the completion of the course of medical instruction required.

Applicants under this section must serve at least one year in a service satisfactory to the Board in a hospital located in the United States and approved by the Board for the training of interns. Before a certificate may be issued, the applicant must also pass a written examination prior to commencing an internship in a hospital in the United States, and must also pass an oral and clinical examination at the satisfactory completion of the internship.

The Board may disapprove any foreign medical school or any application if, in the opinion of the Board, the instruction received by the applicant or the courses were not equivalent to that required in this state for a physician and surgeon applicant.

Every applicant for permission to intern in a hospital must file satisfactory documentary evidence showing the following education qualifications:

1. *Preliminary education.* A diploma from a four-year California high school, or its equivalent.

2. *Premedical education.* A three-year, college level course, including the subjects of physics, chemistry and biology, before commencing the course of professional instruction in medicine.

3. *Professional education.* A medical curriculum extending over a period of at least four academic years in a medical school, the course of study totaling at least 4,000 hours education in the subjects specified. (See Business and Professions Code of California.)

If the applicant has studied in more than one medical school, he

must file a satisfactory Certificate of Medical Education, showing subjects, courses and number of weeks completed, certified by the proper officer of each medical school attended.

Reciprocity

A foreign medical school graduate, whose application for admission to practice in California is based upon a certificate issued by the medical licensing authority of some other state, or is based upon a diplomate certificate issued by the National Board of Medical Examiners of the United States, must show that at the time he was issued the certificate, he had fulfilled all the qualifications of the California Law in effect *at that time* concerning graduates of foreign medical schools.

In addition, if qualified, he must take and pass an oral, clinical and written examination.

For further information write to: Secretary, Board of Medical Examiners, Sacramento 14, California.

COLORADO

Full United States citizenship is required for application.

One year of internship in the U.S. is required in a hospital approved for this purpose by the American Medical Association. Also:

- The school of graduation must be approved by this Board and the A.M.A. and the Association of American Medical Colleges.
- A basic science examination and certificate is needed.
- There is no distinction between native and foreign-born applicants educated outside the United States.
- There is no reciprocity given for foreign graduates.

For further information write to: Secretary, State Board of Medical Examiners, 831 Republic Building, Denver 21, Colorado. Include citizenship, medical college, intern service.

CONNECTICUT

At least first papers are required. There is an approved list of foreign medical schools; for these graduates there is no special hospital training required. No distinction is made between native and foreign born whose medical education has been taken outside the United States.

A basic science examination is necessary for all applicants.

For further information write to: Executive Secretary, Board of Medical Examiners, 160 St. Ronan Street, New Haven, Connecticut.

dieting

—like some drugs—can cause side effects that may force your patient to discontinue treatment

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WASHINGTON REPORT

Current news items of special interest to residents and reserve medical officers, reported directly to your journal by the Army, Navy, Air Force, Veterans Administration and the Public Health Service.

AIR FORCE

TRAINING WITH PAY . . .
Civilian physicians holding Reserve commissions in the Air Force Medical Service now number over 2600 including residents in training who have been deferred under the Berry Plan. Many holding Reserve commissions have affiliated with local Mobilization Assignee Programs for inactive training plus a 15-day tour of active duty each year.

Mobilization assignees are trained at an active Air Force medical facility in the specific position for which they best qualify. In the event of hostilities, the assignee will replace a regular hospital staff officer for more urgent duty elsewhere. He earns regular promotion and retirement credits under this program and is paid the equivalent of two days pay in his Reserve grade whenever he participates in inactive duty training of a full eight hour day. He also serves the 15-day tour of active duty at this facility, perhaps replacing a regular hospital staff officer who is on leave or attending special courses.

Reserve training is also available under the Air Force Medical Reserve unit program. The unit program has been expanded as of April 1957. Large Air Force hospital organizations, casualty staging units, and aeromedical evacuation units comprise the unit program. Reservists in this program normally spend one weekend each month training with other reservists from the same area. For a full weekend of inactive duty training, they receive four days pay in their Reserve grade with credit towards promotion and retirement.

Physicians who wish to take advantage of these opportunities for extra income and training and at

the same time accumulate promotion and retirement credits under the Reserve program should contact the nearest Air Force Reserve activity or write to the Commander, Air Reserve Records Center, Continental Air Command, 3800 York Street, Denver 5, Colorado.

AVOID ERRORS . . .

As of July 1 this year, participants in the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program (the "Berry" Plan) will total approximately 500, representing nearly every approved hospital and medical center in the United States.

Participants applying for commissions and active duty in the Air Force are handled on a first-come-first-served basis. Some applications are being returned to the applicant for *failure to include complete information.* When this happens, final action may be held up too long for the application to receive favorable priority action. Training spaces in the Primary Course in Aviation Medicine may already be filled, or the desired spaces for entrance upon active duty at a specified time may be filled before the Air Force can act upon the application.

These failures to include complete information are of several kinds. Some fail to place their signatures on the fingerprint card. Others fail to inclose photostat copies of essential documents (proof of graduation, etc.) Still others fail to send a personal photograph. Many fail to obtain necessary signatures of witnesses. One form, which asks for information on the naturalization of parents and parents-in-law, requires the date, place, and various details of naturalization, including the naturalization number. If any of these are omitted the application must be returned to the individual. Other applicants overlook the request for a refraction as well as a measurement of vision requested on "Form 88." When any part of the application is returned for additional information, the chances for favorable priority action are always reduced.

Applications are usually acted upon within 90-120 days. This allows for approval and evaluation of the application at the various administrative levels responsible for action. Individuals are advised to insure against any delay caused by their own inaccuracy or oversight.

PUBLIC HEALTH

DEFERMENT PLAN . . .

The Public Health Service has had a residency deferment plan patterned after the Berry Plan in operation for the past two years. The first year a total of 26 residents

were deferred at the request of the Public Health Service by Selective Service under the plan. This year, the total number of deferments authorized was increased to 100 in view of our expanding needs for trained medical officers.

Deferments under this year's quota are now being deferred at the present time.

Major specialties in which residents are being deferred included psychiatry, internal medicine, ophthalmology and surgery. In view of operating program needs, we are especially interested in obtaining applicants this year for residency deferment in pathology, psychiatry, pediatrics, obstetrics and gynecology, and ophthalmology.

NAVY

HOSPITAL CORPS . . .

Hospital corps Division 12-1 located at the U. S. Naval Hospital, Oakland, California was activated on 1 February 1957 with membership consisting of four officers and 44 enlisted hospital corpsmen.

Interested and eligible Reserve Medical Department personnel residing in the San Francisco area who desire to affiliate with this new pay unit should communicate with the Reserve Medical Program Officer of the Twelfth Naval District.

Authorization for the establishment and activation of Hospital Corps Divisions, in all continental Naval Districts, is contained in BuPers Instruction 3500.16 dated 12 September 1956. This new program replaces the one with designated Surface Divisions which formerly trained Reserve hospital corpsmen. It affords the interested and eligible Medical Department officer and enlisted reservist (less Dental) an excellent opportunity to participate in the Reserve program in a pay status and deserves your active support.

Reserve Medical Department personnel desiring to affiliate with or to activate a Hospital Corps Division should write or visit the Medical Reserve Program Officer of their Naval District.

CORRESPONDENCE COURSES

Correspondence courses are necessary for promotion of Naval Reserve officers on inactive duty and for the accumulation of retirement credits. The following *basic* and *general courses* are available to all eligible Medical Department personnel. (These courses are in addition to the Medical Department Correspondence Courses published from time to time in this section.) *Until further notice, specific courses for promotion of inactive Reserve Medical Department officers are not re-*

Navy Courses and Credits

COURSE	NavPer Number	Assignments	Retirement and/or Promotion Points
Administration of Officer's Messes	10970	6	12
Appropriation and Cost Accounting	10984	8	16
Claims	10727	3	6
Combat Information Center	10952	12	24
Education and Training, Part I	10965-I	7	14
Education and Training, Part II	10966	5	10
Foundations of National Power	10770-A1	12	24
General Communications	10916-A	7	14
#General Aerology	10954-A	6	12
Industrial Management	10947	10	20
#International Law	10717-A	12	24
Investigations	10726	2	4
Leadership	10903	5	10
Logistics	10902	6	12
Military Government	10718	7	7
Military Justice in the Navy	10993	12	24
Naval Arctic Operations	10946	5	10
#Naval Orientation	10900-I	11	24
Navy Public Information	10720-I	6	12
Navy Real Estate Law	10989	6	12
Navy Regulations	10740-A	12	24
Navy Travel	10977	2	5
Nucleonics for the Navy	10901	8	24
Organization for National Security	10721	5	10
Personnel Administration	10968	6	12
Photography	10957	8	16
Photographic Interpretation	10958-A	9	18
Radiological Defense	10771	7	14
#Security of Classified Matter	10975-A1	3	6
Uniform Code of Military Justice	10971	1	4
Water Supply and Sanitation	10750	6	12
Welfare and Recreation	10969	12	24

#Designates a revised course (NavPers number or letter changed to indicate revision). Officers who complete this course, even though they completed course under old NavPers number, will receive point credit indicated. Exception: Naval Orientation, NavPers 10900-1 brings one-half credit for completion by those who have completed 10900.

quired. Eligible officers may enroll in *any BuMed or below listed BuPers course* and receive proper credit for promotion.

NOTE: *Material for many courses is in short supply, therefore, all applications submitted should list a second choice.* Requests for enrollment should be addressed to the U. S. Naval Correspondence Course Center, Building RF, U. S. Naval Base, Brooklyn 1, New York.

Applications should be submitted as follows:

- If you are a member of or associated with a pay unit forward via your unit commanding officer and such other official channels as may be locally prescribed.

- If you are not a member of or associated with a pay unit forward via your district commandant.

Additional correspondence courses, on various Medical Department subjects, are available and a complete list of these courses can be obtained by writing the Commanding Officer, U. S. Naval Medical School, Correspondence Training Division, National Naval Medical Center, Bethesda 14, Maryland.

MEDICO-DENTAL SYMPOSIUM

The Eighth Annual Military Medico-Dental Symposium will be held at the U. S. Naval Hospital, Philadelphia, Pennsylvania, October 23-25, 1957.

The Chief of Naval Personnel has approved this symposium for the awarding of retirement point credits to eligible Naval Reserve Medical Department officers attending. Security clearance is not required.

Inquiries concerning the program, accommodations and items of general interest in and around Philadelphia, should be addressed to the District Medical Officer, Headquarters, Fourth Naval District, Naval Base, Philadelphia, Pennsylvania.

TRUE PHYSICIANSHIP

". . . What people found wanting in the doctors of their own day, they thought of as having existed in Hippocrates, who thus became a perpetual exhortation, a prick to conscience, a leader on the road to true physicianship. Along these lines he will continue to manifest his power."

—HENRY E. SIGERIST,
The Great Doctors

Mediquiz

Questions are from a civil service examination given to candidates for physician appointments in municipal government.

Answers on page 169

1. In a fracture of the femoral neck, the one of the following most likely to predispose to bony union is: (A) a varus deformity of the head fragment; (B) a valgus deformity of the head fragment; (C) a normal relationship between head and neck; (D) external rotation of the neck on the head.

2. Of the following nerves, the one most commonly injured in a dislocation of the shoulder is: (A) median; (B) axillary; (C) radial; (D) ulnar.

3. Persistent wrist pain on forcing the extremes of pronation and supination following a Colles' fracture can most frequently be relieved by an operative procedure on the: (A) radius; (B) ulna; (C) radiocarpal ligaments; (D) pronator quadratus.

4. During the first six months following a fractured elbow and after the primary injury has healed, the therapeutic program of choice for the management of progressive stiffening of the joint accompanied by the roentegenological appearance of calcification in the region of the brachialis muscle is: (A) normal use within pain limits; (B) restriction of use; (C) physiotherapy and passive stretching of the joint; (D) complete rest of the joint by use of a splint.

5. A patient is admitted with an incomplete tranverse fissure fracture through the shaft of the femur. X-rays demonstrate the bone to be somewhat bowed with coarse trabeculations and a thickened cortex. He also complains of deafness and tinnitus. The condition most likely to be found responsible for the latter complaints is: (A) Paget's disease; (B) Addison's disease; (C) hyperthyroidism; (D) rickets.

6. Following a penetrating wound at the base of the neck in the pos-

terior cervical triangle, it is noted that there is a drooping of the shoulder with a wing scapula rotated downwards and outwards, and there is an abnormal contour of the base of the neck. The most likely lesion is damage to the: (A) long thoracic nerve of Bell; (B) dorsal scapula nerve; (C) spinal accessory nerve; (D) supra scapula nerve.

7. In a postero-lateral herniation of a lumbar intervertebral disk the nucleus pulposus most often ruptures the: (A) ligamentum flavum; (B) annulus fibrosus; (C) dentate ligament; (D) interspinous ligament.

8. Symptoms indicating operation for traumatic subdural hematoma most frequently occur: (A) at any time from hours to months after injury; (B) a few hours after a head injury; (C) a few months after injury; (D) within the first few hours, or a few months after injury.

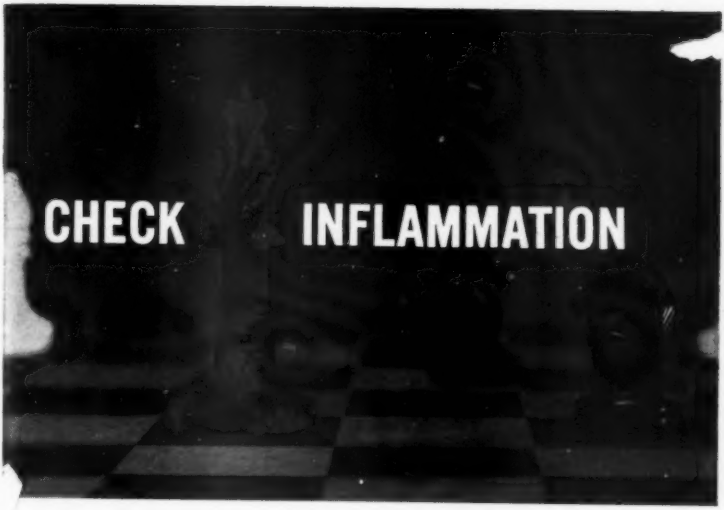
9. The one of the following traumatic lesions in which a fracture of the skull is nearly always present is (A) contusion of the brain; (B) subarachnoid hemorrhage; (C) laceration of the brain; (D) hemorrhage from the middle meningeal artery.

10. A patient is very ill with pneumonia despite large doses of antibiotics. Suddenly he develops weakness of the left arm and leg and becomes semi-stuporous. The stupor gradually clears and the weakness of the left side improves a little, but after three weeks a papilledema of four diopters appears. The patient is probably suffering from: (A) meningitis; (B) brain abscess; (C) cerebral thrombosis with softening; (D) cerebral hemorrhage.

11. An adult develops over a period of months weakness and numbness of the entire left side of his face. He has been almost totally deaf in the left ear for five years. The most likely diagnosis is a: (A) tumor of the eighth nerve; (B) neuritis; (C) chronic otitis media or petrositis; (D) cerebral tumor.

12. Following a bullet wound of the upper third of the arm, a patient shows, in addition to other signs, atrophy of the thenar eminence and inability to flex the distal phalanx of the index finger. He most likely sustained an injury of the: (A) brachial artery; (B) ulnar nerve; (C) median nerve; (D) radial nerve.

13. A male, 50 years of age, experienced a severe pain in the left inguinal region while lifting a heavy object. Examination revealed a direct inguinal hernia. Of the following, the anatomical structure which was primarily involved is the: (A) external oblique fascia; (B) transversalis fascia; (C) transversus ab-



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1. Miller, J. M.; Surmonte, J. A.; Ginsberg, M., and Ablondi, F. B.: Postgraduate Medicine 20:260 (Sept.) 1956.

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Resident Physician

domenus muscle; (D) conjoined tendon.

14. A normal knee joint in ten degrees of flexion shows some lateral instability. Of the following, this instability is due to injury of: (A) cruciate ligaments; (B) fibular collateral ligament; (C) tibial collateral ligament; (D) tibial collateral ligaments and cruciate ligaments.

15. All structures of the anterior aspect of the left wrist, 3 inches proximal to the flexor crease, are severed by a knife. Preparations for surgical repair have been completed. The wrist is viewed in the anatomical position. The structures are identified prior to repair. The flexor carpi radialis muscle lies: (A) anterior to the tendons of the flexor digitorum sublimis; (B) posterior to the tendons of the flexor digitorum sublimis; (C) lateral to the tendons of the flexor digitorum sublimis; (D) medial to the tendons of the flexor digitorum sublimis.

16. In the normal anatomical relationship of the bones to the wrist joint, the greater multangular (trapezium) articulates with: (A) lunate and third metacarpal; (B) lunate and second metacarpal; (C) navicular and first metacarpal; (D) triquetrum and lunate.

17. A patient with a third degree burn of the dorsum of the hand and fingers has the greatest assurance

of a good functional result, if the treatment followed is: (A) pressure dressings with skin grafting in 4 to 6 weeks; (B) daily dressings with antibiotic ointment; (C) daily active motion in warm saline with skin grafting in 3 to 4 weeks; (D) daily active motion in warm saline with skin grafting in 10 to 14 days.

18. Of the following places of work, cases of byssinosis are most likely to be found in: (A) mines; (B) foundries; (C) wood-working shops; (D) cotton mills.

19. A simple complete fracture of the upper third radius is sustained by a young adult. Close reduction is attempted. To obtain an adequate reduction, the arm and hand should be held in: (A) pronation; (B) supination; (C) mid-position; (D) extension.

20. At the present time a number of substances are used in place of lead in the manufacture of paints. Of the following, the one which is not used for this purpose is: (A) litharge; (B) zinc oxide; (C) lithopone; (D) titanium oxide.

21. In determining the source of an outbreak of food poisoning traced to a particular meal, the most important step is to: (A) examine bacteriologically every item of food

served at the meal; (B) determine the attack rates for each food served for those who partook of the food and those who did not partake of the food; (C) examine the stools of all who became ill; (D) examine the stools of all food handlers who prepared the meal.

22. Orthotolidine is commonly used in testing for: (A) bacteria in milk; (B) bacteria in water; (C) arsenic in food; (D) chlorine in water.

23. Gram for gram the one of the following foods which is the richest source of nicotinic acid is: (A) banana; (B) corn meal; (C) calf liver; (D) spinach.

24. In a trichinosis law suit, the item of food which was most likely the cause of trichinosis was: (A) raw ground beef; (B) pork processed under federal inspection for consumption without additional cooking; (C) federally inspected fresh ham eaten raw; (D) homemade thoroughly cooked sausage.

25. A veteran with known and treated schistosomiases acquired on Leyte develops, two years later, convulsions and signs of an expanding intracranial lesion. This is probably: (A) a malignant brain tumor; (B) a hydatid cyst; (C) schistosomiases of the brain; (D) an amebic abscess.

26. Aneurysm of the abdominal

aorta is usually caused by: (A) syphilis; (B) Erdheim's medial necrosis; (C) arteriosclerosis; (D) trauma.

27. In chronic constrictive pericarditis the end diastolic filling pressure in the right ventricle, compared to normal, is: (A) decreased; (B) the same; (C) increased; (D) variable.

28. Lipping and osteophyte formation of the spine by x-ray examination is characteristic and diagnostic of (A) Marie Struempell spondylosis or rheumatoid arthritis of the spine; (B) gonorrheal arthritis of the spine; (C) metastatic invasion of the spine; (D) osteoarthritis of the spine.

29. In the Wolff-Parkinson-White syndrome, the paroxysmal tachycardia which occurs usually has its origin in: (A) His's bundle; (B) the ventricles; (C) Kent's bundle; (D) the auricles.

30. In a patient with evidence of obstructive jaundice, a palpable enlargement of the gall-bladder suggests: (A) an obstruction of the common duct due to extrinsic pres-

sure; (B) carcinoma of the gallbladder; (C) calculus in common duct; (D) suppurative cholangitis.

31. In acute infectious hepatitis with jaundice, an increasing urobilinogenuria is evidence of: (A) complicating extra-hepatic obstruction; (B) progressive liver necrosis; (C) diminishing intra-hepatic obstruction; (D) marked intra-hepatic obstruction.

32. A thirty-two-year-old man with an eight-year history of peptic ulcers is seen in the hospital, three hours after a copious hematemesis. This is his first bleeding episode. His skin and mucous membranes are pale; extremities are warm. Pulse rate is 90 per minute, regular and good quality. His blood pressure is 116 over 70. The hematocrit is 43%, hemoglobin is 12.6 grams, the RBC is 3,800.000. The preferred initial treatment would be: (A) blood transfusion 500 cc; (B) plasma transfusion 500 cc; (C) either (A) or (B), and 1000 cc of 5% glucose in saline by clysis; (D) sedation and the initiation of a modified feeding regimen.

MEDIQUIZ ANSWERS

1 (B), 2 (B), 3 (B), 4 (A), 5 (A), 6 (C), 7 (B), 8 (A), 9 (D), 10 (B), 11 (A), 12 (C), 13 (B), 14 (B), 15 (A or C), 16 (C), 17 (D), 18 (D), 19 (B), 20 (A), 21 (B), 22 (D), 23 (C), 24 (C), 25 (C), 26 (C), 27 (C), 28 (D), 29 (D), 30 (A), 31 (C), 32 (D).

What's the Doctor's Name?

By James Gallagher

He was born February 15, 1829, the son of a physician and the grandson of a physician. Yet when he himself suggested the study of medicine his father objected that he had no appreciation of the life, having brains but no industry. His study, research and industry were to prove his father wrong and make him known as an outstanding American physician, author and pioneer in the application of psychology to medicine. His most recent biographer, Ernest Earnest, suggests that "he took psychiatry out of the madhouse and brought it into everyday life."

He took his degree at Jefferson Medical College in 1850, and for the rest of his life he combined medical practice with research. He wrote on clinical medicine, comparative physiology, and toxology, achiev-

ing special fame for his treatment of nervous disorders and studies of the nervous system.

His famous rest treatment is recorded in *Fat and Blood* (1877). His work *Injuries to the Nerves and Their Consequences* was published as early as 1864, while his last medical book, *The Medical Department in the Civil War*, appeared shortly before his death on January 4, 1914.

He was for years a trustee of the University of Pennsylvania, president of the Association of American Physicians, of the American Neurological Association, and of the College of Physicians, Philadelphia. Of his novels, all of which have an intellectual quality unusual in his day, the best known are *Hugh Wynne, The Adventures of Francois, Dr. North and His Friends, Constance Trescott*, and *The Red City*.

His friend, Walt Whitman, of *Leaves of Grass* fame, summed him up as well as anyone ever has: "He is my friend—has proved it in divers ways: is not quite as easy going as our crowd—has a social position to maintain yet I don't know but he's as near right in most things as most people. I can't say that he's a world-author—he don't hit me for that size—but he's a world-doctor for me—leastwise everybody says so and I join in."

Can you name this doctor without turning to page 178?

Leads and Needs

Rates

Personal classified advertising rates are $3.00 for ads of thirty words or less plus 10c for each additional word. When a box number is used and answers sent care of RESIDENT PHYSICIAN there is an additional charge of 50c. Add four additional words for a box.

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ALL CLASSIFIED ADS PAYABLE IN ADVANCE. Forms close 15th of month prior to date of issue. RESIDENT PHYSICIAN, 1447 Northern Boulevard, Manhasset, New York.

PHYSICIANS WANTED

GENERAL PHYSICIANS wanted: Under 35 years of age; to assist specialists in professional care program of the 10 Miners Memorial Hospitals; full time positions with starting compensation at the rate of $12,000 per year; U. S. citizenship and eligibility for licensure in Kentucky, Virginia or West Virginia required. For details, address: The Clinical Director, Miners Memorial Hospital Ass'n, 1427 Eye Street, N.W., Washington 5, D.C.

YOUNG PHYSICIAN interested in working in Southern W. Va. industrial and general practice. W. Va. license required. Contact: N. F. Coulon, M.D., Gary, W. Va.

PHYSICIANS WANTED — Full-time staff NP Veterans Hospital affiliated in psychiatric residency training program. Jefferson Barracks, 23, Missouri; 12 miles from downtown St. Louis; salary $7570 to $12,685 depending upon qualifications; prefer those with psychiatric experience or interest; 25% additional salary (up to $13,760) if board certified; must be U.S. citizens. Write: Manager, VA Hospital, Jefferson Barracks, 23, Missouri.

GENERAL PRACTITIONER wanted—in excellent farming community; new combination office and dwelling; new hospital 12 miles away; new industry employing 100 men recently established. Contact: O. A. Kutter, Compton, Illinois.

RESIDENTS WANTED

PATHOLOGY RESIDENCY: An immediate opening exists for a resident in pathology at the VA Research Hospital, affiliated with Northwestern University Medical School and allied hospitals. Three full-time, board certified pathologists in charge; close association with staff of Northwestern University. Ample opportunity for special studies in academic atmosphere. 229 autopsies, 2000 surgical specimens last year. Appointment subject to review by Dean's Committee. Fully approved. Apply: Director, Professional Services, VA Research Hospital, 333 E. Huron Street, Chicago 11, Illinois.

ASSISTANT PATHOLOGISTS—Person with Four years training or Board eligible; starting salary $8,000; present staff consisting of 3 pathologists, biochemist, microbiologist and part-time hematologist; 195 autopsies and 11,000 surgicals annually. Address communications to: Dr. Tobias Weinberg, Pathologist-in-Chief, Sinai Hospital, Baltimore 5, Maryland.

HOMES AND OFFICES FOR SALE

DERMATOLOGICAL PRACTICE in Oklahoma for sale due to death; long established; fully equipped office in air-conditioned building; will introduce to patients. Mrs. Chas. P. Bondurant, 253 N.W. 35, Oklahoma City, Oklahoma.

MARYLAND—Established general practice in Eastern Shore town on Chesapeake Bay. Thirteen miles from modern open-staff hospital. Large new office consists of two consultation and two examination rooms, large waiting room, and is equipped with a 100 MA Century II X-ray machine (one year old). Office may be rented for $125. per month or purchased outright if desired. Write: Willard F. Smith, M.D., Rock Hall, Maryland.

Excellent CALIFORNIA GENERAL PRACTICE for sale; in small Southern California city; available hospital facilities; price includes equipment (office, examining, physio-therapy, X-ray and completely-equipped licensed laboratory), property and 2 buildings; last year gross $43,000; terms. Write: Ed L. Lindmark, 480 Barry Drive, Pomona, California.

PENNSYLVANIA—Excellent opportunity; near Scranton, Pennsylvania; well-established lucrative practice; rural area; great need; office equipped with x-ray and E.K.G.; 10 miles from new hospital. Reply: Mrs. Mack, Lake Ariel, Penna.

HOMES AND OFFICES FOR SALE

OFFICE available—Completely equipped for immediate occupancy due to sudden death of general practitioner; practice established 25 years; excellent opportunity. Contact: Mrs. James Stephenson, Everett, Penna.

OPPORTUNITIES in Southern California. Carefully researched areas for unopposed private practice; suites in new medical buildings available for lease. George O. Shecter Associates, 1834 Pandora Ave., Los Angeles, California.

BUFFALO, N. Y.—2½ story home with fully equipped, modern, spacious doctor's office. Excellent location, near 2 large hospitals; due to illness. Mrs. B. Engelman, 911 Elmwood Ave., Buffalo 22, New York.

EQUIPMENT FOR SALE

Largest Stock of Used—Reconditioned and surplus X-ray equipment in America—All makes and models of diagnostic and therapy units, delivered, installed, guaranteed and serviced; write for details and new accessory price list. Medical Salvage Co., Inc., 217 East 23rd Street, New York 10, New York.

CAMP PHYSICIAN WANTED

CAMP PHYSICIAN WANTED—July, August Vermont Girls Camp. Camp Birchwood, 315 West End Avenue, New York 23, N. Y., telephone TR. 7-9790 Miss Dell.

PRINTING and RECORDS

Resident Physician Advertisers' Index May 1957

WHAT'S THE DOCTOR'S NAME?

(from page 171)

SILAS WEIR MITCHELL

(Last Month's Doctor: JOHN KEATS)

VIEWBOX DIAGNOSIS

(from page 13)

PSEUDOPOLYPOSIS

Note numerous small nodular elevations of the mucosa in a colon which is smoothened, lacks haustral segmentation and is narrowed.

RESIDENT RELAXER

(puzzle on page 15)